COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CONTRACT TO PROVIDE MANAGED CARE SERVICES FOR THE FAMILY ACCESS TO MEDICAL SECURITY INSURANCE (FAMIS) PROGRAM

July 2007

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CONTRACT FOR SERVICES

BETWEEN

THE VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

AND

_____

(Contractor)

The Department of Medical Assistance Services (herein referred to as the "Department"), an agency of the Commonwealth of Virginia, and the successful bidding managed care organization (MCO) (herein referred to as the "Contractor"), an organization which makes available to enrollees, in consideration of periodic fixed payments, comprehensive health care services provided by providers selected by the entity who are employees or partners of the entity or who have entered into a referral or contractual (subcontracting) arrangement with the entity, for the purpose of providing and paying for FAMIS contract services to enrollees in the MCO under the FAMIS State Plan approved by the Commonwealth of Virginia and by the Secretary of the United States Department of Health and Human Services, pursuant to Title XXI of the Social Security Act, in consideration of the mutual covenants, agreements, and promises contained herein, the parties hereto, intending to be legally bound, do herewith agree with the terms outlined in the following Contract.

The Department and the Contractor, as defined in section 160.103 of the Final HIPAA Privacy Rule, have entered into this Contractor Agreement to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Final Privacy regulation requirements for such an Agreement, as well as our duty to protect the confidentiality and integrity of Protected Health Information (PHI) required by law, Department policy, professional ethics, and accreditation requirements. Parties signing this contract shall fully comply with the provisions of
the regulations implementing HIPAA.

ARTICLE I – DEFINITIONS & ACRONYMS

Abuse - (i) use of health services by recipients which is inconsistent with sound fiscal or medical practices and that results in unnecessary costs to the Virginia Medicaid program or in reimbursement for a level of use or a pattern of services that is not medically necessary, or (ii) provider practices which are inconsistent with sound fiscal or medical practices and that result in (a) unnecessary costs to the Virginia Medicaid program, or (b) reimbursement for a level of use or a pattern of services that is not medically necessary or that fails to meet professionally recognized standards for health care.

Actuarially Sound Capitation Rates – Capitation rates that have been developed in accordance with generally accepted actuarial principles and practices; are appropriate for the populations to be covered and the services to be furnished under the contract; and have been certified by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

Appeal - Any written communication made by or on behalf of the enrollee expressing dissatisfaction with the results of a Grievance resolution. An appeal is usually handled by an MCO representative who was not involved in the grievance process or by a committee comprised of individuals who are not employed by the MCO such as an independent review body.

Audit: An audit refers to a formal review of compliance with a particular set of internal (e.g., policies and procedures) or external (e.g., laws and regulations) standards used as Base measures.

Capitation Payment - A payment the Department makes periodically to a contractor on behalf of each enrollee enrolled under a contract for the provision of medical services under the State plan, regardless of whether the particular enrollee receives services during the period covered by the fee.

Capitation Rate - The monthly amount, payable to the Contractor, per enrollee, for all expenses incurred by the Contractor in the provision of contract services as defined herein.

Carved-Out Services - The subset of FAMIS covered services that the Contractor shall not be responsible for covering under the FAMIS program.

Case Management –The Contractor is required to develop alternative treatment plans for a patient who would otherwise require more expensive services, including, but not limited to, long-term inpatient care. Inpatient care may be authorized in a variety of settings in order to meet a specific need.

Centers for Medicare & Medicaid Services (CMS) - The Federal agency of the United States Department of Health and Human Services that is responsible for the administration of Title XIX and Title XXI of the Social Security Act.

Central Processing Unit (CPU) - An independent contractor, hereinafter referred to as designated agent, who, in conjunction with the Department, determines FAMIS eligibility for and administers part of the Family Access to Medical Insurance Security Plan for FAMIS.

Childhood Obesity – In accordance with The Center for Health and Health Care in Schools, Childhood Obesity is defined as an age-specific Body Mass Index (BMI) that is greater than the ninety-fifth (95th) percentile. Children are considered at risk if their BMI-for-age is greater than the eighty-fifth (85^{th}) percentile but less than the ninety-fifth (95^{th}) percentile.

Clean Claim - A claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim.

Complaint A grievance .

Contract - This signed and executed document.

Contract Amendment - Any changes or amendment to the Contract that are mutually agreed to in writing by the Contractor and the Department or are mandated by changes in Federal or State laws or regulations.

Contractor - Any entity that contracts with the Department, under the State plan and in return for a payment, to process claims, to pay for or provide medical services, or to enhance the Department's capability for effective administration of the program.

Cost Sharing – Co-payments paid by the FAMIS enrollee in order to receive medical services.

Covered Services - The subset of FAMIS covered services that the Contractor shall be responsible for covering under the FAMIS program.

Cultural Competency - A competency based on the premise of respect for individuals and cultural differences, and an implementation of a trust-promoting method of inquiry and assistance.

Data Analysis - Tool for identifying potential payment errors and trends in utilization, referral patterns, formulary changes, and other indicators of potential fraud, waste or abuse. Data analysis compares claim information and other related data to identify potential errors and /or potential fraud by claim individually or in the aggregate. Data analysis is an integrated, on-going component of fraud detection and prevention activity.

Days - Business days, unless otherwise specified.

Department - The Virginia Department of Medical Assistance Services.

Disease Management – System of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant.

Disenrollment - The process of changing enrollment from one FAMIS MCO to another MCO or ceasing eligibility and coverage.

Drug Efficacy Study Implementation (DESI) – Drugs for which Virginia FAMIS will not provide reimbursement because the drugs have been determined by the Food and Drug Administration (FDA) to lack substantial evidence of effectiveness.

Early Intervention – Services provided through Part C of the Individuals with Disabilities Education Act (20 U.S.C. §1471 et seq.), as amended, designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development. These services are provided to children from birth to age three who have (i) a twenty-five percent developmental delay in one or more areas of development, (ii) atypical development, or (iii) a handicapping condition.

Eligible Person - A person eligible for Virginia FAMIS in accordance with the State Plan of the Virginia Child Health Insurance Plan under Title XXI of the Social Security Act who has been certified and enrolled by the Department and designated agent as such through the FAMIS eligibility.

Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.

Emergency Services – Covered inpatient and outpatient services furnished by participating or non-participating qualified providers that are necessary to evaluate, treat or stabilize an emergency medical condition, as defined above.

Employer Sponsored Health Insurance (ESHI) - Comprehensive health insurance coverage offered by the employer when the employer contributes at least forty percent towards the cost of dependent or family coverage, or as otherwise approved by the Centers for Medicare and Medicaid Services (CMS).

Encounter – Any covered or enhanced service received by an Enrollee through the Contractor or its subcontractor.

Encryption – A security measure process involving the conversion of data into a format, which cannot be interpreted by outside parties.

Enhanced Services - Services offered by the MCO Contractor to enrollees in addition to FAMIS covered services. The Department will not pay for enhanced services.

Enrollee – As it relates to this contract is a child eligible for FAMIS who is enrolled with an MCO Contractor to receive services under the provisions of this Contract.

Enrollment - The completion of approved enrollment forms, by or on behalf of an eligible person and assignment of an enrollee to an MCO by the Department or its designated agent in accordance with the terms of this Contract.

Enrollment Area - The counties and municipalities in which an eligible organization is authorized by the Commonwealth of Virginia pursuant to a Contract to operate as a FAMIS Contractor and in which service capability exists as defined by the Commonwealth.

Enrollment Period – The time that an enrollee is enrolled in a Department approved MCO during which they may not disenroll or change MCOs.

Excluded Entity - Any provider or subcontractor that is excluded from participating in the Contractor's health plan as defined in Article II, Section J.6, of this Contract.

Expedited Appeal –The process by which an MCO must respond to an appeal by an enrollee if a denial of care decision by an MCO may jeopardize life, health or ability to regain maximum function. The decision must be rendered within 72 hours of the enrollee appeal.

Experimental/Investigative Procedures - Describes any service or supply which is judged to be experimental or investigative at the Department's sole discretion. The Department will apply the criteria outlined in the benchmark plan to determine if a procedure qualifies as experimental/investigative.

External Quality Review Organization (EQRO) – the independent contractor assigned by DMAS to handle quality reviews and to conduct final review of MCO determinations to FAMIS.

FAMIS MOMS Recipients – Recipients who are uninsured pregnant females, not eligible for Medicaid with family income at or below 150% of the federal poverty level, and who are assigned and enrolled in the aid category of 05. Covered services for FAMIS MOMs are the same as the covered services for Medallion II enrollees.

Family Planning –Those services that delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility or services to promote fertility.

FAMIS Plus Recipients - Children who meet "medically indigent" criteria under Medicaid program rules, and who are assigned an aid category of 90; 91 (under 6 years of age); 92, 93 and 94. FAMIS Plus children receive the full Medicaid benefit package and have no cost sharing responsibilities.

Federally Qualified Health Centers (FQHCs) – Those facilities as defined in 42 C.F.R. § 405.2401(b), as amended.

Fee-for-Service - The traditional Medicaid health care payment system in which physicians and other providers receive a payment for each unit of service they provide. This method of reimbursement is not used by the Department to reimburse the Contractor under the terms of this Contract.

Formulary – A list of drugs that the MCO has approved. Prescribing some of the drugs may require prior authorization.

Fraud - Intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in payment of an unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state laws.

Fraud Control Unit - The unit established within the Office of the Attorney General to audit and investigate providers of services furnished under the Virginia State Plan for FAMIS, as provided for in the *Code of Virginia* § 32.1-320, as amended.

Generally Accepted Accounting Principles (GAAP) - Uniform minimum standards of and guidelines to financial accounting and reporting as established by the Financial Accounting Standards Board and the Governmental Accounting Standards Board.

Grievance - A written communication submitted by or on behalf of an enrollee expressing dissatisfaction with the resolution of a complaint. Grievances are usually handled by the MCO's Internal Grievance Committee and are related to: 1) the availability, delivery or quality of health care services including the utilization review decisions that are adverse to the enrollee or, 2) payment or reimbursement of health care service claims.

Guardian – A person appointed by the court who is responsible for the personal affairs of an incapacitated person as defined in § 37.1-134.6 of the *Code of Virginia*.

Health Insurance Portability & Accountability Act of 1996 (HIPAA) - Title II of HIPAA requires standardization of electronic patient health, administrative and financial data; unique health identifiers for individuals, employers, health plans, and health care providers; and security standards protecting the confidentiality and integrity of individually identifiable health information past, present, or future.

Healthy Returns – The Department' disease state management program administered by Health Management Corporation (HMC). Healthy Returns is a disease management program designed to help patients better understand and manage coronary artery disease, congestive heart failure, asthma, chronic obstructive pulmonary disease, and diabetes through prevention, education, lifestyle changes, and adherence to prescribed plans of care (POCs). The program is for the Medicaid and FAMIS fee-for-service populations.

Home and Community-Based Care Services (HCBS) - Medicaid community-based care programs operating in the Commonwealth under the authority of §1915(c) of the Social Security Act, 42 U.S.C. §1396 n (c) including but not limited to the waivers for AIDS, Elderly and Disabled (E&D), Consumer Directed Personal Attendant Services (CDPAS), Mental Retardation, Alzheimer's, Technology Assisted, Individual and Family Developmental Disabilities Support (DD), and Day Support.

Hospital - A facility that meets the requirements of 42 C.F.R. § 482, as amended.

Informational Materials – Written communications from the Contractor to enrollees that educate and inform enrollees about services, policies, procedures, or programs specifically related to FAMIS.

Inquiry – An oral or written communication made by or on the behalf of an enrollee that may be: 1) questions regarding the need for additional information about eligibility, benefits, plan requirement or materials received etc., 2) provision of information regarding a change in the enrollee's status such as address, family composition, etc., or; 3) a request for assistance such as selecting or changing a MCO assignment, obtaining translation assistance, obtaining access to care, etc. Inquiries are not expressions of dissatisfaction.

Institute for Mental Disease - Institution for mental diseases means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases.

Laboratory - Any laboratory performing testing for the purpose of providing information for the diagnosis, prevention, or treatment of disease or impairment, or the assessment of the health of human beings, and which meets the requirements of 42 C.F.R. § 493.3, as amended.

Managed Care Organization - – An organization which offers managed care health insurance plans, (MCHIP) as defined by Virginia Code § 38.2-5800 which means an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which (i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier. Any health maintenance organization as defined in § 38.2-4300 or health carrier that offers preferred provider contracts or policies as defined in § 38.2-3407 or preferred provider subscription contracts as defined in § 38.2-4209 shall be deemed to be offering one or more MCHIPs. For the purposes of this definition, the prohibition of balance billing by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are directly or indirectly managed, owned, under contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple products and multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks.

Marketing Materials - Any materials that are produced in any medium, by or on behalf of an MCO; are used by the MCO to communicate with individuals who are not its enrollees; and can reasonably be interpreted as intended to influence the individuals to enroll in that particular MCO and entity.

Marketing Services - Any services rendered or activities conducted by the Contractor or its subcontractors to its prospective enrollees for the purpose of education or providing information that can reasonably be interpreted as intended to influence the enrollee to enroll in that particular MCO's FAMIS product.

Medallion II Covered Services - The subset of Medicaid/FAMIS Plus covered services which the Contractor shall be responsible for covering under the Medallion II program. FAMIS MOMs enrollees receive the Medallion II benefit package.

Medicaid Management Information System (MMIS) - The medical assistance and payment information system of the Virginia Department of Medical Assistance.

Medical Necessity – "Medical Necessity" or "medically necessary" means appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience. Services must be sufficient in amount, duration and scope to reasonably achieve their purpose.

Monthly-_For the purposes of contract reporting requirements, monthly shall be defined as the 15th day of each month for the prior months reporting period. For example, January's monthly reports are due by February 15th; February's are due by March 15th, etc.

National Provider Identifier (NPI) - NPI is a national health identifier for all typical health care providers, as defined by CMS. The NPI is a numeric 10-digit identifier, consisting of 9 numbers plus a check-digit . It is accommodated in all electronic standard transactions and many paper transactions. The assigned NPI does not expire.

Network Provider - The health care entity or health care professional that is either employed by or has executed an agreement with the Contractor, or its subcontractor, to render covered services, as defined in this Contract, to enrollees.

Newborn Guarantee Coverage Period - The time period between the date of birth of a child whose mother is a FAMIS enrollee with the Contractor until the last day of the third calendar month including the month of birth.

Non-Covered Services - Services not covered by Virginia FAMIS and, therefore, not included in covered services as defined in the Virginia State Child Health Plan or State regulations.

Non-Participating Provider - A health care entity or health care professional not in the Contractor's participating providers network.

Open Enrollment – Time frame defined by the Department as the 60-day period prior to the end of the enrollee's annual re-evaluation period. Before this 60-day time frame an enrollee must be notified of their ability to disenroll or change MCOs during the re-evaluation period.

Out-of-Network Coverage - Coverage provided outside of the established MCO network; medical care rendered to an enrollee by a provider not affiliated with the Contractor or contracted with the Contractor.

Party in Interest - Any director, officer, partner, agent, or employee responsible for management or administration of the Contract; any person who is directly or indirectly the beneficial owner of more than five percent (5 percent) of the equity of the Contractor; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by and valuing more than five percent (5 percent) of the Contractor; or, in the case of a Contractor organized as a nonprofit corporation or other nonprofit organization, an incorporation or enrollee of such corporation under applicable State corporation law. Additionally, any organization in which a person previously described is a director, officer or partner, that has directly or indirectly a beneficial interest of more than five percent (5 percent) of the equity of the Contractor or has a mortgage, deed of trust, note, or other interest valuing more than five percent (5 percent) of the assets of the Contractor; any person directly or indirectly controlling, controlled by, or under common control with the Contractor; or any spouse, child, or parent of a previously described individual.

Person with Ownership or Control Interest - A person or corporation that owns, directly or indirectly, five percent (5 percent) or more of the Contractor's capital or stock or received five percent (5 percent) of the total assets of the Contractor in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the Contractor or by its property or assets, or is an officer, director, or partner of the Contractor.

Post Stabilization Services – Covered services related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition.

Primary Care Provider (PCP) - A practitioner who provides preventive and primary medical care for eligible FAMIS enrollees and who certifies prior authorizations and referrals for all medically necessary specialty services. PCPs may include pediatricians, family and general practitioners, internists, obstetrician/gynecologists, and specialists who perform primary care functions for children, clinics, including but not limited to health departments, Federally Qualified Health Centers (FQHCs) , Rural Health Clinics (RHCs), etc.

Prior Authorization (PA) Program – The Department's prior authorization program for fee-for-service Medicaid and for carved-out services. KePro is the Department's contractor for prior authorization services.

Protected Health Information (PHI) - Individually identifiable information, including demographics, which relates to a person's health, health care, or payment for health care. HIPAA protects individually identifiable health information transmitted or maintained in any form or medium.

Quarterly – For the purposes of contract reporting requirements, quarterly shall be defined as within 30 calendar days of the end of each calendar quarter.

Quarters - Calendar quarters starting on January 1, April 1, July 1, and October 1.

Rural Area - A census designated area outside of a metropolitan statistical area.

Rural Health Clinic – A facility as defined in 42 C.F. R. § 491.2, as amended.

School Health Services- School health services are defined as physical therapy, occupational therapy, speech therapy, nursing, school health assistance, psychiatric and psychological services rendered to children who qualify for these services under the federal Individuals with Disabilities Education Act (20 USC § 1471 et seq.) by (i) employees of the school divisions or (ii) providers that subcontracted with school divisions, as described in 12 VAC 30-50-229.1. School Health Services are carved out of this contract and are reimbursed directly by DMAS.

State Child Health Plan (State Plan) - The comprehensive written statement submitted to HCFA/CMS by the Department describing the nature and scope of the Virginia FAMIS program and giving assurance that it will be administered in conformity with the requirements, standards, procedures and conditions for obtaining Federal financial participation. The Department has the authority to administer the State Plan for Virginia under *Code of Virginia* § 32.1-351, as amended.

Subcontract - A written contract between the Contractor and a third party, under which the third party performs any one or more of the Contractor's obligations or functional responsibilities under this Contract.

Subcontractor - A State approved entity that contracts with the Contractor to perform part of the Contractor's responsibilities under this contract. For the purposes of this contract, the subcontractor's providers shall also be considered providers of the Contractor.

Subtance Abuse – means the use of drugs, without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior and (iii), because of such substance abuse, requires care and treatment for the health of the individual. This care and treatment may include counseling, rehabilitation, or medical or psychiatric care.

Successor Law or Regulation - That section of Federal or State law or regulation which replaces any specific law or regulation cited in this Contract. The successor law or regulation shall be that same law or regulation if changes in numbering occur and no other changes occur to the appropriate cite. In the event that any law or regulation cited in this contract is amended, changed or repealed, the applicable successor law or regulation shall be determined and applied by the Department in its sole discretion. The Department may apply any source of law to succeed any other source of law. The Department shall provide the Contractor written notification of determination of successor law or regulation.

Third-Party Liability - Any entity (including other government programs or insurance) which is or may be liable to pay all or part of the medical cost for injury, disease, or disability of an applicant or enrollee of FAMIS.

Urban Area - Places of 2,500 or more persons incorporated as cities, villages, boroughs, and towns but excluding the rural portions of "extended cities" according to the US Department of Commerce, Bureau of the Census.

Urgent Medical Condition - A medical (physical, mental, or dental) condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of medical attention within twenty-four (24) hours could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in:

a) Placing the patient's health in serious jeopardy;
b) Serious impairment to bodily function;
c) Serious dysfunction of any bodily organ or part; or
d) In the case of a pregnant woman, serious jeopardy to the health of the unborn child.

Utilization Management – The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria.

Value-Added Network (VAN) - A third party entity (e.g. vendor) that provides hardware and/or software communication services, which meet the security standards of telecommunication.

Well Baby and Well Child Services - Those services rendered for the routine care of a child under age nineteen (19).

COMMONLY USED CONTRACT AND MEDICAID/FAMIS RELATED ACRONYMS

ABD -- Aged, Blind, and Disabled Population
ACIP -- Advisory Committee on Immunization Practice
ANSI -- American National Standards Institute
APN -- Administrative Provider Number
ASP -- Application Service Provider

BBA -- Balanced Budget Act of 1997
BOI -- Bureau of Insurance of the Virginia State Corporation Commission

CAD -- Coronary Artery Disease
CAHPS™-- Consumer Assessment of Health Plans Survey
CFR -- Code of Federal Regulations
CHF -- Congestive Heart Failure
CMS -- Centers for Medicare and Medicaid Services
COB -- Coordination of Benefits
COPD -- Chronic Obstructive Pulmonary Disease
CORFs -- Comprehensive Outpatient Rehabilitation Facilities
CPT -- Current Procedural Terminology
CSB -- Community Service Board
CSHCN -- Children with Special Health Care Needs
CY -- Calendar Year

DBA -- Dental Benefits Administrator
DD -- Individual and Family Developmental Disabilities Support
DESI--Drug Efficacy Study Implementation
DHHS -- Department of Health and Human Services
DMAS -- Department of Medical Assistance Services
DME -- Durable Medical Equipment
DMHMRSAS -- Department of Mental Health, Mental Retardation, and Substance Abuse Services
DOB -- Date of Birth
DRG -- Diagnosis Relative Grouping
DSP -- Data Security Plan
DSS -- Department of Social Services

EN -- Enteral Nutrition
EOC -- Evidence of Coverage
EOM – End of Month
EPA -- Environmental Protection Agency
EQR -- External Quality Review
EQRO -- External Quality Review Organization
ER – Emergency Room

FAMIS -- Family Access to Medical Insurance Security
FAMIS Plus -- Medicaid Enrolled Children
FIPS -- Federal Information Processing Standards
FOIA -- Freedom of Information Act
FQHC -- Federally Qualified Health Centers
FTE -- Full-Time Equivalent
FTP -- File Transfer Protocol

GAAP -- Generally Accepted Accounting Principles

HCBS -- Home and Community-Based Care Services
HEDIS -- Health Plan Employer Data and Information Set
HIPAA -- Health Insurance Portability and Accountability Act of 1996

HIV/AIDS -- Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HR -- Healthy Returns

IBNR -- Incurred But Not Reported
ID -- Identification
IDEA -- Individuals with Disabilities Education Act.
IEP -- Individual Education Plan
ICF/MR -- Intermediate Care Facility/Mental Retardation

KEPRO -- Keystone Peer Review Organization

LCSW -- Licensed Clinical Social Worker

MATE -- Medical Assistance to Employment
MCHIP -- Managed Care Health Insurance Plans
MCO -- Managed Care Organization
MMIS -- Medicaid Management Information System
MPRO -- Michigan Peer Review Organization

NCPDP -- National Council for Prescription Drug Programs
NCQA -- National Committee for Quality Assurance
NPI -- National Provider Identifier

OB/GYN -- Obstetrician and Gynecologist
OT -- Occupational Therapy
PA -- Prior Authorization
PACE – Program of All-inclusive Care for the Elderly
PCCM -- Primary Care Case Management
PCP -- Primary Care Provider
PHI -- Protected Health Information
PIRS -- Patient Intensity Rating Survey
POC -- Plan of Care
PROV -- Provider
PSA -- Prostate Specific Antigen
PT -- Physical Therapy
QI -- Quality Improvement

QIP -- Quality Improvement Program
RFP -- Request For Proposal
RHC -- Rural Health Clinics
RN -- Registered Nurse
RTF -- Residential Treatment Facility

SLP -- Speech-Language Pathology
SPO -- State Plan Options
SSI -- Social Security Insurance
SSN -- Social Security Number

State Plan -- State Plan for Medical Assistance

TB -- Tuberculosis
TDO -- Temporary Detention Order
TFCCM -- Treatment Foster Care Case Management
TMJ -- Temporomandibular Joint (disorder)
TPL -- Third-Party Liability
TPN -- Total Parenteral Nutrition

Title XIX -- Medicaid
Title XXI -- SCHIP
TTY/TDD -- Teletype/Telecommunication Device for the Deaf

UB-92 -- Universal Billing 1992 claim form
UM -- Utilization Management
U.S.C. -- United States Code

VAC -- Virginia Administrative Code
VAMMIS -- Virginia Medicaid Management Information System
VPN -- Virtual Private Network

WIC -- Women, Infants, and Children Special Supplement Nutrition program

XYZ -- Any Named Entity

ARTICLE II - FUNCTIONS AND DUTIES OF CONTRACTOR

A. REQUIREMENTS TO CONDUCT BUSINESS

1. Statutory and State Licensing and Certification Requirements

The Contractor shall retain at all times during the period of this Contract a valid license issued by the Virginia State Corporation Commission's Bureau of Insurance and comply with all terms and conditions set forth in the *Code of Virginia* §38.2-4300 through 38.2-4323, 14VAC5-210-10 *et. seq.*, §38.2-5800 through 38.2-5811, and any and all other applicable laws of the Commonwealth of Virginia, as amended.

Pursuant to §32.1-137.1 through §32.137.7 Code of Virginia, and 12VAC5-408-10 et. seq., all managed care health insurance plan licensees must obtain service area approval certification and remain certified by the State Health Commissioner Center for Quality Health Care Services and Consumer Protection to confirm the quality of health care services they deliver.

2. In and Out-of-State Providers

A Contractor licensed in Virginia may include in its provider network providers which are located across State boundaries, as long as all such providers are necessary for the delivery of services to enrollees in a particular locality.
The Contractor may also utilize in-state and out-of-state providers, who are not enrolled as FAMIS providers; however, the Contractor must make a best effort to enroll all providers in Virginia FAMIS/Medicaid as a FAMIS/Medicaid provider.

3. Financial Statements

a. The Contractor shall submit to the Department a copy of all quarterly and annual filings submitted to the Bureau of Insurance. A copy of such filing shall be submitted to the Department on the same day on which it is submitted to the Bureau of Insurance.

   Any revisions to a quarterly and/or annual BOI financial statement shall be submitted to the Department on the same day on which it is submitted to the BOI.

b. The Contractor shall agree to work with the Provider Reimbursement Division of the Department to develop a financial report that details medical expenditure categories total enrollee months related to the expenditures, Incurred But Not Paid (IBNP) amounts, and all administrative expenses associated with the FAMIS program. The Department reserves the right to approve the final format of the report. (Attachment I will be modified to reflect final changes to the report.) The report shall be submitted on a quarterly basis to the Department. The first quarterly reporting period shall

begin on July 1 and end on September 30. This report is subject to audit and verification by the Department.

4. Financial Records

Throughout the duration of the Contract term, the Contractor shall operate and maintain an accounting system that either (1) meets Generally Accepted Accounting Principles (GAAP) as established by the Financial Accounting Standards Board, or (2) can be reconciled to meet GAAP. This accounting system shall have the capability to produce standard financial reports and ad hoc financial reports related to financial transactions and ongoing business activities, and the Contractor shall enhance or update it upon request. Prior to Contract signature, the Contractor must notify the Department about the basis of accounting the Contractor will be using. Throughout the term of the Contract, the Contractor must notify the Department prior to making any changes to its basis of accounting.

5. Financial Solvency Information

The Bureau of Insurance of the Virginia State Corporation Commission regulates the financial stability of all licensed MCOs in Virginia. The Contractor agrees to comply with all Bureau of Insurance standards. Entities that are not licensed by the Bureau of Insurance must meet all risk and reserve requirements outlined by the Bureau.

6. Changes in Reserves

The Contractor shall report to the Department within two (2) business days of any sanctions or changes in reserve requirements imposed by the Bureau of Insurance or any other entity.

7. Business Transactions Reporting

The Contractor, whether an HMO or not, shall comply with §1318 of the Health Maintenance Organization Act (42 U.S.C. §300e, *et seq.)*, as amended, which requires the disclosure and justification of certain transactions between the Contractor and any related party, referred to as a Party in Interest. Transactions reported under 42 U.S.C. §300e, *et seq.,* as amended, must be justified as to their reasonableness and potential adverse impact on fiscal soundness.

The information provided for transactions between the Contractor and a Party in Interest will include the following:

a. The name of the Party in Interest in each transaction;

b A description of each transaction and if applicable, the quantity of units involved;

c. The accrued dollar value of each transaction during the calendar year; and

d. A justification of the reasonableness of each transaction.

The Contractor shall notify the Department within five (5) calendar days after any publicly announced acquisition agreement, pre-merger agreement, or pre-sale agreement impacting the Contractor's ownership. Business transactions to be disclosed include, but are not limited to:

a. Any sale, exchange, or lease of any property between the Contractor and a Party in Interest;

b. Any lending of money or other extension of credit between the Contractor and a Party in Interest; and

c. Any furnishing for consideration of goods, services (including management services) or facilities between the Contractor and a Party in Interest. Business transactions for purposes of this section do not include salaries paid to employees for services provided in the normal course of employment by the Contractor.

At least five (5) calendar days prior to any change in ownership, the Contractor must provide to the Department information concerning each Person with Ownership or Control Interest as defined in this Contract. This information includes but is not limited to the following:

a. Name, address, and official position;
b. A biographical summary;
c. A statement as to whether the person with ownership or control interest is related to any other person with ownership or control interest such as a spouse, parent, child, or sibling;
d. The name of any organization in which the person with ownership or control interest in the Contractor also has an ownership or control interest, to the extent obtainable from the other organization by the Contractor through reasonable written request. The Contractor must keep copies of all written requests and responses and provide them to the Department when requested; and
e. The identity of any person, principal, agent, managing employee, or key provider of health care services who (1) has been convicted of a criminal offense related to that individual's or entity's involvement in any program under FAMIS or Medicare since the inception of those programs (1965) or (2) has been excluded from the Medicare and FAMIS programs for any reason. This disclosure must be in compliance with §1128, as amended, of the Social Security Act, 42 U.S.C. §1320a-7, as amended, and 42 C.F.R. §455.106, as amended, and must be submitted on behalf of the Contractor and any subcontractor as well as any provider of health care services or supplies.

Federal regulations contained in 42 C.F.R. §455.104 and 42 C.F.R. §455.106 also require disclosure of all entities with which a FAMIS provider has an ownership or control relationship. The Contractor shall provide information concerning each Person with Ownership or Control.

8. Changes in Key Staff Positions

To promote continual effective communication, the Contractor must notify the Department in writing of changes in key staff positions, particularly the Contract Administrator, Chief Financial Officer, Medical Director, Case Management staff, Member Services/Operations Manager, and Information Technology staff within fifteen (15) calendar days of any change. These changes are to be reported when individuals are either lost or added to these key positions.

9. Conflict of Interest Safeguards

In accordance with 1932(d)(3) of the Social Security Act, the Contractor shall comply with conflict of interest safeguards with respect to officers and employees of the Department having responsibilities relating to this contract. Such safeguards shall be at least as effective as described in the Federal Procurement Policy Act (41 U.S.C. section 27) against conflicts of interest that apply with respect to Federal procurement officials with comparable responsibilities with respect to such contracts.

10. Medical Management

The Contractor shall provide local medical management through licensed registered nurses (RNs) or individuals with appropriate professional clinical expertise to perform case management activities for the Contractor's FAMIS enrollees. The Contractor shall have a full-time, Virginia-based medical director who is a Virginia-licensed medical doctor. Medical management staffing shall be at a level that is sufficient to perform all necessary medical assessments and to meet all FAMIS enrollees' case management needs at all times.

11. Responsiveness to the Department

The Contractor shall acknowledge receipt of the Department's written, electronic, or telephonic requests for assistance, including case management requests, involving enrollees or providers as expeditiously as the enrollee's health condition requires or no later than within two business (2) days of receipt of the request from the Department. The Contractor's acknowledgement must include a planned date of resolution. A detailed resolution summary advising the Department of the Contractor's action and resolution shall be rendered to the Department in the format requested. The Department's requests for case management services and/or requests for the Contractor to contact the enrollee/provider must occur within the time frame set forth by the Department.

The Department's urgent requests for assistance such as issues involving legislators, other governmental bodies, or as determined by the Department, must be given priority by the Contractor and completed in accordance with the request of and instructions from the Department. The Department shall provide guidance with respect to any necessary deadlines or other requirements. A resolution summary, as described by the Department shall be submitted to the Department.

12. Base of Operations

The Contractor shall have a dedicated Virginia Medicaid project manager located in an operations/business office within the Commonwealth of Virginia. The Virginia project manager shall be authorized and empowered to make operational and financial decisions including rate negotiations for Virginia business, claim payment, and provider relations/contracting. The project manager shall be able to make decisions about managed care expansions and shall represent the Contractor at the Department's meetings. The Virginia-based location must include a designee who can respond to issues involving systems and reporting, appeals, quality assessment, member services, EPSDT services management, pharmacy management, medical management, and case management. The Virginia office shall include a Virginia licensed and Virginia based medical director and dedicated staff able to perform member advocacy and provider network development. Provider relations staff shall be located within the geographic region where the contractor operates. Member Advocates must assist enrollees in writing complaints and are responsible for monitoring the complaint through the Contractor's complaint process. The Department does not require claims, medical management, customer service, pharmacy management, or member services to be physically located in Virginia.

Prior to diverting any of the specified key personnel for any reason, the Contractor shall notify the Department within two (2) business days of the decision and shall submit justification (including proposed substitutions) in sufficient detail to permit evaluation of the impact on the delivery of covered services.

13. Cultural Competency

The Contractor must demonstrate cultural competency in its dealing, both written and verbal, with enrollees and must understand that cultural differences between the provider and the member cannot be permitted to present barriers to access and quality health care and demonstrate the ability to provide quality health care across a variety of cultures.

B. SUBCONTRACTOR MANAGEMENT AND MONITORING

The Contractor may enter into subcontracts for the provision or administration of any or all FAMIS covered services or enhanced services. Subcontracting does not relieve the Contractor of its responsibilities to the Department or enrollees under this Contract. The

Department shall hold the Contractor accountable for all actions of the subcontractor and its providers. Additionally, for the purposes of this contract, the subcontractor's providers shall be considered providers of the Contractor. This includes subcontracts for dental, vision, mental health, prescription drugs, or other providers.

All subcontracts entered into pursuant to this Contract shall meet the following delegation and monitoring requirements.

The Contractor must ensure that subcontractors and providers in their networks are licensed by the State and have received proper certification or training to perform the specific services for which they are contracted. The Contractor shall neither participate with nor enter into any provider agreement with any individual or entity that has been excluded from participation in federal health care programs.

1. Delegation Requirements

a. All subcontracts shall be in writing,

b. Subcontracts shall fulfill the requirements of this Contract and applicable Federal and State laws and regulations,

c. Subcontracts shall specify the activities and reporting responsibilities delegated to the subcontractor, and

d. Subcontracts shall provide provisions for revoking delegation or imposing sanctions in the event that the subcontractor's performance is inadequate.

2. Monitoring Requirements

a. The Contractor shall perform on-going monitoring of all subcontractors.

b. The Contractor shall perform a formal review of all subcontractors at least annually.

c. The Contractor shall monitor encounter data of its subcontractor before the data is submitted to the Department. The Contractor shall apply certain key edits to the data to ensure accuracy and completeness. These edits shall include, but not be limited to, recipient and provider identification numbers, dates of service, diagnosis and procedure codes, etc.

d. As a result of monitoring activities conducted by the Contractor (through on-going monitoring and/or annual review), the Contractor shall identify to the subcontractor deficiencies or areas for improvement, and shall require the subcontractor to take appropriate corrective action.

To the extent that the Contractor uses one or more subcontractors or agents to provide services under the Contract, and such subcontractors or agents receive or have access to the Protected Health Information (PHI), each such subcontractor or agent shall sign an agreement with the Contractor that complies with HIPAA.

The Contractor shall ensure that any agents and subcontractors to whom it provides PHI received from the Department (or created or received by The Contractor on behalf of the Department) agree in writing to the same restrictions, terms, and conditions relating to PHI that apply to the Contractor in this Contract. The Department shall review and approve all such written agreements between The Contractor and its agents and subcontractors prior to their effectiveness.

All subcontracts entered into pursuant to this Contract shall be in writing and fulfill the requirements of this Contract and applicable Federal and State laws and regulations. For example, all contracts must ensure the level and quality of care required under this Contract.

Subcontracts with the Contractor for delegated, administrative and medical services in the areas of planning, finance, reporting systems, administration, quality assessment, credentialing, recredentialing, utilization management, enrollee services, claims processing, or provider services must be submitted to the Department at least thirty (30) calendar days prior to their effective date. This includes subcontracts for vision mental health, prescription drugs or other providers of service. All subcontracts are subject to the Department's written approval. The Department may revoke such approval, if the Department determines that the subcontractors fail to meet the requirement of this Contract. Subcontracts which require the subcontractor to be responsible for the provision of FAMIS covered services must include the terms set forth in Attachment IV, and, for the purposes of this Contract, that subcontractor shall be considered both a subcontractor and network provider. Subcontracts will be considered approved if the Department has not responded within thirty (30) calendar days of the date of departmental receipt of request.

All subcontracts must ensure the level and quality of care required under this Contract.
The Contractor shall require all its subcontractors to submit to the Department, for review and approval, all mass-generated letters intended for provider and/or enrollee distribution, 30 days prior to their planned distribution. This does not include materials for wellness or business purposes, but does extend to letters to generate provider enrollment or advising enrollees of enrollment/disenrollment or other Department functions. The Department shall review and return these documents with any recommended changes within three (3) business days (Note: this turnaround time does not apply to review of handbook booklets, contractor marketing materials, or other mailings whose review process is identified elsewhere in this contract.)

C. MARKETING MATERIALS AND SERVICES

For the purposes of this Contract, "Marketing Materials and Services" activities as defined shall apply to FAMIS enrollees. All Contractors are encouraged to utilize subcontractors for marketing purposes; however, Contractors will be held responsible by the Department for the marketing activities and actions of subcontractors who market on their behalf. Marketing and outreach activities shall not be included in the capitation payment rate to MCOs and shall not be a reimbursable expense to the MCOs.

1. Marketing Services

The Contractor shall:

a. Offer its plan to FAMIS enrollees and provide to the parents or guardians of those interested in enrolling adequate, written descriptions of the MCO's rules, procedures, benefits, fees and other charges, services, and other information necessary for enrollees to make an informed decision about enrollment.

b. The Contractor shall utilize Department designed and approved brochures, application and enrollment forms to provide to the parents or guardians of potential enrollees that lists all the possible MCO choices available in the enrollees' locality/region.

c. Ensure that all promotional items and materials are approved by the Department prior to printing and distribution. The Contractor may include the name of the MCO and a general phone number for the MCO in the designated space on the Department's designed and approved FAMIS materials. The Department will approve, deny, or ask for modifications to the materials within thirty (30) days of the date of receipt by the Department.

d. Order FAMIS brochures, applications and other materials via the FAMIS website or by contacting the FAMIS Outreach Manager.

2. Allowable MCO Marketing Activities

Allowable marketing activities include but are not limited to: distribution and posting of written promotional materials pre-approved by the Department; networking, giveaways that are of a reasonable dollar amount so as not to be an incentive; mail campaigns to regions of parents or guardians of potential enrollees; fulfillment of requests from parents or guardians of potential enrollees to the MCO for general information, brochures and/or provider directories; marketing at community sites; hosting or participating in health awareness events, community events, and health fairs and screenings.

The Contractor must make available informational material that includes the Department approved MCO health plan information.

3. Use of the FAMIS Logo

The MCOs may utilize the Department designed FAMIS logo on member identification cards and member handbooks. All items or materials containing the FAMIS logo must be pre-approved by the Department prior to final printing and distribution. The FAMIS logo shall not be used on non-FAMIS items or materials.

The FAMIS logo must be used exactly as it is designed and shall not be altered in any way. The MCO has the option of using the logo in a black and white format or the color format, however, if the color format is utilized the colors shall not be changed, nor shall it be reversed out.

MCOs may use the logo on member identification cards without the approved tag line. All other use of the logo must include the tag line and FAMIS phone number.

4. Prohibited Marketing and Outreach Activities

The MCOs are prohibited from the following marketing and outreach activities targeting prospective FAMIS enrollees under this Contract:

a. Engaging in any informational or marketing activities which could mislead, confuse, or defraud enrollees or misrepresent the Department.

b. Marketing the FAMIS program as a program specific to their company/organization. The Contractor shall market the FAMIS program as a program of the Commonwealth of Virginia. Materials shall indicate that FAMIS is a program of the Commonwealth, administered by DMAS in partnership with (name of MCO).

c. Direct marketing to any child under nineteen (19) years of age.

d. Offering financial incentive, cash rewards, cash gifts, or to eligible enrollees or the parent or guardian of any potential enrollee as an inducement to enroll in the Contractor's plan other than to offer the health care benefits from the Contractor pursuant to their FAMIS contract or as permitted above.

e. Using the health status or medical condition of any individual who is identified as a prospective FAMIS member for purposes of marketing. If a medical or eligibility database is used to identify prospective FAMIS members for purposes of marketing, the Contractor must ensure that there is no violation of member confidentiality. Only the names of prospective members may be used, not the health status or medical condition of the individual.

f. Engaging in marketing or informational activities that target prospective enrollees on the basis of health status or future need for health care

services, or which otherwise may discriminate against individuals eligible for health care services.

g. Making home visits for marketing or enrollment activities unless at the request of the potential enrollee's parent or guardian.

h. No assertion or statement (whether written or oral) that the Contractor is endorsed by the Center for Medicare and Medicaid Services (CMS); Federal or State government; or similar entity.

i. No assertion or statement that the recipient must enroll with the Contractor in order to keep from losing benefits.

D. ELIGIBILITY AND ENROLLMENT

In conducting any enrollment-related activities permitted by this Contract or otherwise approved by the Department, the Contractor shall assure that enrollee enrollment is voluntary and without regard to health status, physical or mental condition or handicap, age, sex, national original, race, or creed. The Contractor shall notify the enrollee of his or her enrollment in the Contractor's plan through a letter submitted simultaneously with the enrollee handbook. Eligible children shall be covered by FAMIS benefits effective the first day of the month of application for FAMIS. An application is defined as the date a signed application form is received by the CPU or the local Department of Social Services (DSS) office and stamped in. The enrollee shall receive services under the fee-for-service component until enrollment in an MCO is complete.

The Department has contracted with a firm that will provide many of the administrative services of the FAMIS program. The Central Processing Unit (CPU), hereinafter referred to as the "designated agent," will facilitate enrollment in FAMIS, including a telephone call center, applications processing, eligibility determinations, MCO enrollment, cost-sharing monitoring, reporting, and multiple electronic interfaces.

1. Enrollment Process into a Contracting MCO

Eligible enrollees shall be enrolled into participating, locality-specific FAMIS MCOs via an electronic database. The enrollee shall be enrolled into the designated plan immediately upon verification of eligibility to be effective with the next available enrollment cycle. The last date to enroll in order to become effective in the next enrollment cycle shall be designated by the Department. The effective date of enrollment shall be the first day of the next month.

The MCO shall create and maintain an electronic mechanism that will allow for the download of enrollee eligibility and enrollment information. The data elements transferred shall include, but are not limited to enrollee name, ID number, address, date of birth, age, sex, race, social security number, if available.

The MCO shall be responsible for generating a plan membership package that includes the FAMIS membership card, provider directory, enrollee handbook and evidence of coverage.

Individuals who are eligible and enrolled in the Virginia Birth-Related Neurological Injury Compensation Fund, commonly known as the Birth Injury Fund are excluded from managed care enrollment.

There shall be no retroactive enrollment in managed care.

2. File Transmission

The MCOs shall receive via electronic mechanism, the enrollment and capitation payment information and reports. The MCO shall accept enrollment and capitation payment information on a monthly basis, as well as by transaction type. The MCO shall establish a mechanism to accept the electronic transfer of funds from the Department or its fiscal agent for the capitation payments.

3. Individuals Excluded from FAMIS

The Contractor shall cover all FAMIS eligible individuals, with the exception of individuals excluded from FAMIS MCOs by the Department. The Contractor shall not cover any services rendered in free-standing psychiatric hospitals to enrollees up to nineteen (19) years of age, unless as an enhanced benefit. Inpatient psychiatric services rendered in a psychiatric unit of a general acute care hospital shall be covered for all FAMIS eligible enrollees.

4. Enrollment of Newborns

Any newborn whose mother is a FAMIS enrollee enrolled in the Contractor's plan on his or her date of birth shall be deemed an enrollee of that MCO for three calendar months (the birth month plus two months). The newborn's continued enrollment with the Contractor is not contingent upon the mother's enrollment. The Department shall reimburse the Contractor appropriate capitation for a newborn of an enrolled recipient during the birth month plus two additional months. The charges for newborns to mothers enrolled with the Contractor are the responsibility of the Contractor in all cases. The Contractor may not deny payment to a provider as a result of DSS or FAMIS CPU newborn enrollment errors.

To remain an enrollee of the Contractor's plan, the infant must be identified through established enrollment procedures. Infants born to mothers enrolled with FAMIS who do not receive a FAMIS identification number prior to the end of the third month will be canceled. The Contractor is responsible for advising the Department monthly of all newborns born to a mother who is a FAMIS enrollee. The Contractor is responsible for advising the mother/guardian that in order to receive coverage for the newborn, the CPU must be notified of the birth. Additionally, the Contractor is responsible for advising the

Department quarterly of all live birth outcomes via electronic report using the format reflected in Attachment XIII.

5. Assignment to MCOs

The Department or its designated agent shall enroll enrollees directly into the MCO. If no enrollment response is received from the enrollee by the last day to enroll, the Department or its designated agent shall randomly assign enrollees to locality specific MCOs or to the MCO of other FAMIS eligible children in the family. In areas with one participating MCO, all FAMIS enrollees shall be assigned to that MCO.

The Contractor shall be responsible for keeping its network of providers informed of the enrollment status of each enrollee. The Contractor shall be able to report and ensure enrollment to network providers through electronic means.

6. Open Enrollment

Clients will be notified of their ability to change plans at least sixty (60) days before the end of the annual eligibility re-evaluation period. MCOs that have contractual enrollment limits shall be able to retain existing enrollees who select them and shall be able to participate in open enrollment until contractual limits are met.

7. Enrollment Period

Following their initial enrollment into an MCO, FAMIS enrollees shall be restricted to that MCO until the next open enrollment period.

For the initial ninety (90) calendar days following the effective date of enrollment, the enrollee will be permitted to disenroll from one MCO to another without cause. One plan change will be allowed without cause during this enrollment period.

If the enrollee does not disenroll during the ninety (90) day period, he/she may not disenroll without cause for the remainder of the 12 month enrollment period.

In addition, within sixty (60) days prior to the end of their enrollment period, the Department's designated agent will inform the enrollee of the opportunity to remain with the current MCO, or change to another MCO without cause. Those enrollees who do not choose a new MCO within sixty (60) days prior to the end of the enrollment period shall remain in his or her current MCO.

8. Disenrollment

Under limited circumstances members may be able to disenroll from one MCO and enroll into another MCO with cause.

a. From MCO for Cause

Cause requests must be in writing to the Department and cite the specific reason(s) why the enrollee wishes to change health plans. The Department will define the reasons under which cause for disenrollment may exist. Cause is available only in areas with more than one MCO and does not allow an enrollee to go into Title XIX programs.

The Department will establish procedures for cause disenrollment. The Department will respond to cause requests in writing within 30 business days of the Department's receipt of requests.

b. From MCO due to Employer Sponsored Health Insurance (ESHI)

Enrollees who are determined eligible to participate in the voluntary employer-sponsored health insurance (ESHI) component of the FAMIS program shall be disenrolled from the MCO. ESHI is a voluntary component for families that have access to health insurance through their employer. FAMIS-eligible children with access to ESHI will be initially enrolled with a FAMIS MCO. Once enrolled in their employer's plan the Department or its designated agent will notify the MCO that the child will be disenrolled from the MCO. The specific timing and procedures will be worked out by the Department to avoid lapses in coverage for these children.

c. From Program due to Loss of FAMIS Eligibility due to Status Change

The enrollee will lose eligibility for FAMIS upon occurrence of any of the following events, (which are not considered in the determination of capitation fees under this Contract):

i. Death of the enrollee;

ii. No longer meet financial or eligibility requirements of the FAMIS program;

iii Transfer to a Medicaid eligibility category including approval by the Department or CMS, as appropriate, of HCBS waivered services; or

iv. Individuals who have other comprehensive group or individual health insurance coverage.

The Department will determine the need for status change disenrollment based on input and supporting documentation from the Contractor and/or other source(s). The Contractor shall not be liable for the payment of any services covered under this Contract rendered to an enrollee after the effective date of the enrollee's exclusion or loss of FAMIS eligibility, except for specially manufactured DME

that was prior-authorized by the contractor . However, in cases where disenrollment is anticipated, the Contractor is responsible for the authorization and provision of all services covered under this contract until notified of the disenrollment by the Department or the designated agent.

d. Contractor Transfer of Information Upon Enrollee Disenrollment or Exclusion

The Contractor will assist the Department in collecting data regarding reasons for enrollment and disenrollment in the Contractor's managed care plan.

The Department will share with the Contractor data that its agents have regarding reasons for enrollment and disenrollment, when such information is available.

When an enrollee for whom services have been authorized but not provided as of the effective date of disenrollment or disenrolled from the Contractor's plan and from FAMIS, the Contractor shall provide to the Department or the relevant PCP the history for that enrollee upon request. This prior authorization history shall be provided to the Department or the relevant PCP within five (5) business days of request.

9. Automatic Assignment

The Contractor will accept assignment for any eligible FAMIS enrollee.

10. Automatic Re-Enrollment

Enrollees who were previously enrolled with the Contractor and who regain eligibility for FAMIS enrollment within sixty (60) calendar days of the effective date of exclusion or disenrollment will be reassigned to the Contractor, as appropriate, provided sufficient enrollee slots are available under this Contract.

11. Enrollment Effective Time

All MCO enrollments are effective after the application is deemed complete, and at which time they appear on the enrollment roster. All disenrollments are effective 11:59 p.m. the last day of enrollment. If the disenrollment is the result of a plan change, it is effective the last day of the month. If the disenrollment is the result of any exclusion, it may be effective any day during the month.

12. PCP Notification of Enrollee Panel

The Contractor must have in place policies and procedures that are acceptable to the Department for notifying PCPs of their panel composition within five (5) business days

of the date on which the MCO receives the enrollment roster from the Department or its designated agent.

13. Enrollment Verification

The Contractor must have in place policies and procedures to ensure that in- and out-of-network providers can certify enrollment in the Contractor's plan prior to treating a patient for non-emergency services. The Contract must provide within five (5) business days of the date on which the Contractor receives the enrollment roster from the Department or its designated agent, the ability to verify enrollment by telephone or by another timely mechanism.

14. Choice of Health Professional

The Contractor must have written policies and procedures for assigning each of its enrollees to a PCP. Any changes or modifications to these policies and procedures must be submitted by the Contractor to the Department at least thirty (30) calendar days prior to implementation and must be approved by the Department. The PCP must be specialty appropriate for children.

a. Enrollee Choice of PCP

The Contractor shall offer each enrollee covered under this Contract the opportunity to choose a PCP affiliated with the Contractor to the extent that open panel slots are available at the MCO designated timeframe.

b. Default Assignment of PCP

If the enrollee does not request an available PCP prior to the enrollment effective date, then the Contractor may assign the new enrollee to a PCP within its network, taking into consideration such known factors as current provider relationships, language needs (to the extent they are known), age and sex, enrollment of family members (e.g., siblings), and area of residence. The Contractor then must notify the enrollee in writing, on or before the first effective date of enrollment with the Contractor, of his or her PCP's name, location, and office telephone number.

c. Timing of PCP Assignment

The enrollee must have an assigned PCP from the date of enrollment with the plan.

d. Change of PCP

The Contractor must allow enrollees to select or be assigned to a new PCP when requested by the enrollee, when the Contractor has terminated a PCP, or when a

PCP change is ordered as a part of the resolution to a formal grievance proceeding. When an enrollee changes his or her PCP the Contractor must make the enrollee's medical records or copies thereof available to the new PCP within ten (10) business days from receipt of request.

15. Enrollee Information Packet

The Contractor shall provide each enrollee, prior to the first day of the month in which their enrollment starts an information packet indicating the enrollee's first effective date of enrollment. The Contractor shall utilize at least first class or priority mail delivery services as the medium for providing the enrollee member identification cards. The Department must receive a copy of this enrollee information packet on an annual basis for
review. At a minimum, the enrollee information packet shall include:

a. An introduction letter

b. A FAMIS identification card

c. A Provider Directory listing, including a list of the names, telephone numbers, hours of operation, and service site addresses of primary care providers available for selection, the names and addresses of all other network providers, area of specialty, Board certification, and any areas of expertise of the provider.

d. Enrollee Handbook

The Contractor is required to send the enrollee a new identification card and Enrollee Information Packet upon request by the enrollee.

16. Evidence of Coverage/Enrollee Handbook

The Contractor shall submit a copy of the Enrollee Handbook to the Department for approval thirty (30) calendar days prior to distribution. The Department will respond within thirty (30) calendar days of the date of the Department's receipt of the request. The Enrollee Handbook created for the FAMIS program shall be a separate Handbook document and shall not be an addendum to aHandbook for other programs, e.g. Medallion II.

The Contractor must update the Handbook annually, addressing changes in policies through submission of a cover letter explicitly identifying sections that have changed. Such changes must be approved by the Department prior to dissemination to enrollees and shall be submitted to the Department at least thirty (30) calendar days prior to

planned use. The Department will respond to changes to the Handbook at least thirty (30) calendar days of the date of Departmental receipt of request. If the Department has not responded to the Contractor within thirty (30) days from receipt of the Handbook, the Contractor may proceed with its printing schedule. Any changes to content subsequent to printing shall be corrected through an addendum or subsequent printing mutually agreed upon between the Contractor and the Department.

The Handbook must be provided to each enrollee (and potential enrollee if requested) after the Contractor receives notice of the enrollee's enrollment data from the Department or its designated agent and prior to the first day of the month in which their enrollment starts. The Handbook must include at a minimum the following information:

a. Table of Contents

b. Enrollee Eligibility

c. Choosing or Changing a PCP

d. Making Appointments and Accessing Care

e. Enrollee Services

f. Emergency Care

g. Enrollee Identification Cards

h. Enrollee Responsibilities

i. Complaints, Grievances, and Appeals

j. Translation Services

k. Program or Site Changes

l. Information regarding the enrollee's repayment of capitation premium payments if enrollment is discontinued due to failure to report truthful or accurate information when applying for FAMIS.

E. ENROLLEE IDENTIFICATION CARD

1. Enrollment Verification

The Department or its designated agent shall provide monthly to the Contractor an EDI transmission of all FAMIS enrollees who have selected or been assigned automatically to the Contractor's plan. The transmission, or "enrollment roster," shall be provided to the Contractor sufficiently in advance of the enrollee enrollment effective date to permit the

Contractor to fulfill its identification card issuance and PCP notification responsibilities, described elsewhere in this Contract. Should the enrollment roster be delayed in its delivery to the Contractor, the applicable timeframes for identification card issuance and PCP notification shall be extended by one (1) business day for each day the enrollment roster is delayed. The Department or its designated agent and the Contractor shall reconcile each enrollment roster as expeditiously as is feasible.

The Department or its designated agent shall provide monthly to the Contractor a transmission of all FAMIS enrollees identified as Alaska Natives or American Indians who have selected or been assigned automatically to the Contractor's plan. The file shall be provided to the Contractor sufficiently in advance of the enrollee enrollment effective date to permit the Contractor to fulfill its identification card issuance requirements.

2. Enrollee Identification Card

The Contractor shall provide each enrollee an identification card that is recognizable and acceptable to the Contractor's network providers. The Contractor's identification card must also serve as sufficient evidence of coverage for non-participating providers. The Contractor's identification card will include, at a minimum, the name of the enrollee, a FAMIS identifier, the name and address of the Contractor, the name of the enrollee's primary care provider, the enrollee's co-payment amount, a telephone number to be used to access after-hours non-emergency care, instructions on what to do in an emergency, Medicaid ID number, and a Contractor identification number, if applicable. The Contractor must submit and receive approval of the identification card from the Department for approval prior to production of the cards.

The Contractor shall provide each enrollee, prior to the first day of the month in which their enrollment starts an identification card. The Contractor must be prepared to accept the enrollment report on or after the twentieth (20^{th}) day of each month. The Contractor must mail all enrollee identification cards, utilizing at least first class or priority mail delivery services, in envelopes marked with the phrase "Return Services Requested."
The Contractor shall provide a report to the Department on a monthly basis with the date and the number of identification cards mailed to new members enrolled each month, and the number of identification cards that were re-issued during the prior month. Additionally, the Contractor shall submit a monthly report of returned I.D. cards. The report must identify all returned cards, with the enrollee's identification number, first/last name, incorrect address, and correct address if available.

F. COMMUNICATION STANDARDS

The Contractor must institute a mechanism for all enrollees who do not speak English to communicate effectively with their PCPs and with Contractor staff and subcontractors. In addition, the Contractor must provide TTY/TDD services for the hearing impaired.

The Contractor must make available enrollee handbooks in languages other than English when five percent (5%) of the Contractor's FAMIS enrolled population is non-English

speaking and speaks a common language. The populations will be assessed by FAMIS regions and will only affect handbooks distributed in the affected region.

All enrollment, disenrollment and educational documents and materials made available to FAMIS enrollees by the Contractor must be submitted to the Department for its review annually.

G. PROVISION OF CONTRACT SERVICES

Throughout the term of this Contract, the Contractor shall promptly provide, arrange, purchase or otherwise make available all services required under this Contract to all of its FAMIS enrollees. Services provided to inmates/incarcerated recipients enrolled with the Contractor are not covered. The Contractor shall report monthly to DMAS any recipients it identifies as incarcerated.

1. FAMIS Covered Services

The Contractor shall provide, arrange for, purchase or otherwise make available the full scope of FAMIS services, with the exception of the carve-out services defined in Article II and other exceptions noted in this Article to which persons are entitled under the State Children's Health Insurance Plan as amended and as further defined by written Department policies (including, but not limited to, agreements, statements, FAMIS memorandum, instructions, or memoranda of understanding) and all applicable State and Federal regulations, guidelines, transmittals, and procedures. Brief descriptions of FAMIS covered services are provided in this Article.

In no case shall the Contractor establish more restrictive benefit limits for medically necessary services than those established by FAMIS as defined in the State Children's Health Insurance Plan and other documents identified above. The Contractor shall manage service utilization through utilization review and prior authorization, but not through the establishment of benefit limits for medically necessary services that are more restrictive than those established by FAMIS. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Coverage decisions that depend upon prior authorization and/or concurrent review to determine medical necessity must be supervised by qualified medical professionals and completed within a reasonable period of time after receipt of all necessary information.

The Contractor shall assume responsibility for all covered medical conditions of each enrollee as of the effective date of coverage under the Contract, regardless of the date on which the condition arose. The Contractor shall cover all pre-existing conditions.

2. Abortions

Under the terms of this contract, the Contractor shall not cover services for abortion, as detailed in Attachment II of "Covered Services." All requests for abortions where the

life of the mother is endangered shall be forwarded to the Department for review to ensure compliance with SCHIP rules. The Department will be responsible for payment of abortion services meeting Federal SCHIP requirements under the fee-for-service program.

3. Chiropractic Services

The Contractor shall provide coverage of medically necessary spinal manipulation and outpatient chiropractic services rendered for the treatment of an illness or injury up to $500 per calendar year.

4. Clinic Services

The Contractor shall cover clinic services that are defined as preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are provided to outpatients and are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. With the exception of nurse-midwife services, clinic services are furnished under the direction of a physician. Renal dialysis clinic visits are also covered.

5. Dental and Related Services

a. Services Covered Under Medical

Under the terms of this contract, the Contractor shall not cover routine dental services which are provided by a dental contractor. The Contractor shall assure it has processes in place to refer enrollees seeking routine dental services to the dental contractor. The Contractor will be responsible for medically necessary procedures of the mouth, including but not limited to, the following:

i. CPT codes billed for dental services performed by an MD as a result of a dental accident;

ii. Medically necessary procedures including but not limited to: cleft palate repair, preparation of the mouth for radiation therapy, maxillary or mandibular frenectomy when not related to a dental procedure, orthognathic surgery to attain functional capacity (TMJ), and surgical services on the hard or soft tissue in the mouth where the main purpose is not to treat or help the teeth and their supporting structures.

b. Hospitalization and Anesthesia Related Services

The Contractor shall cover anesthesia and hospitalization for medically necessary dental services as follows:

i Coverage for children under age of 5, persons who are severely disabled, and persons who have a medical condition that requires admission to a hospital or outpatient surgery facility when determined by a licensed dentist, in consultation with the covered person's treating physician, that such services are required to effectively and safely provide dental care.

ii. The DBA will coordinate authorizations for these services using the following procedures:

(a) The dental service provider must submit the request for authorization directly to the DBA;.
(b) The DBA reviews and approves the request for dental related hospitalization and/or anesthesia based upon medical necessity.
(c) The DBA coordinates the authorization with the Contractor and within the Contractor's provider network.

The Contractor shall honor anesthesia and hospitalizations for medically necessary dental services as determined by the DBA. If the Contractor disagrees with the DBA's decision for medical necessity, the Contractor may appeal within two (2) business days of the notification by the DBA of the authorization. The appeal must be made directly with the Department's Dental Benefits Manager. The Department's decision shall be final and shall not be subject to further appeal by the Contractor. The Department's decision, however, does not override any decisions made as part of the recipient's appeals process as described in Section P of this contract.

The Contractor is not required to cover testing of fluoridation levels in well water.

6. Durable Medical Equipment

The Contractor shall cover durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices). Durable medical equipment and prosthetic devices and eyeglasses are covered when medically necessary. There shall be no co-payment for medical supplies. Medical equipment shall have an enrollee appropriate co-payment.

Any specialized DME authorized by the Contractor will be reimbursed by the Contractor, even if the member is no longer enrolled with the plan or with Medicaid. Retraction of the payment for specialized equipment can only be made if the member is retrodisenrolled for any reason by the Department and the effective date of the retrodisenrollment precedes the date the equipment was authorized by the Contractor. The Department and all Contractors must use the valid preauthorization begin date as the invoice date. Specialized equipment includes, but is not limited to, the following:

- Customized wheelchairs and required components;

- Customized prone standers; and,
- Customized positioning devices

For a complete listing of Medicaid covered medical supplies and equipment refer to the Durable Medical Equipment (DME) and Supplies Appendix B of the Medicaid DME Provider Manual, as amended.

7. Early Intervention Services

The Contractor shall cover medically necessary FAMIS covered services for children from birth to age three who are determined eligible for Part C services of the Individuals with Disabilities Education Act by the Department of Mental Health, Mental Retardation and Substance Abuse Services or applicable Early Intervention Intragency Council. Services are covered up to $5,000 per enrollee per calendar year. All services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable. The Contractor or its designated subcontractor may require prior authorization of services for the purposes of determining medical necessity of therapies and services.

8. Emergency Services

The Contractor shall provide for the reasonable reimbursement of services needed to ascertain whether an emergency exists in instances in which the clinical circumstances that existed at the time of the beneficiary's presentation to the emergency room indicate that an emergency may exist.

The Contractor shall ensure that all covered emergency services are available twenty-four (24) hours a day and seven (7) days a week.

The Contractor shall cover all emergency services provided by out-of-network providers. Emergency services provided within the MCO plan's service area shall include covered health care services from nonaffiliated providers. In absence of an agreement to otherwise, all claims for emergency services shall be reimbursed at the applicable Virginia Medicaid fee-for-service rate in effect at the time the service was rendered.

The Contractor may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. Additionally the Contractor shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider or the Contractor of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services. An enrollee who has en emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

The Contractor may not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the "prudent layperson" standard, as defined herein, was in fact non-emergency in nature.

The Contractor may not require prior authorization for emergency services. This applies to out-of-network as well as to in-network services that an enrollee seeks in an emergency.

Enrollees who present to the emergency room shall pay the emergency room co-payment. If it is determined that the visit was a non-emergency, the hospital may bill the enrollee only for the difference between the emergency room and non-emergency co-payments, i.e. $8.00 for ≤150% and $20.00 for >150%. The hospital may not bill for additional charges.

In accordance with Section 1867 of the Social Security Act, hospitals that offer emergency services are required to perform a medical screening examination on all people who come to the hospital seeking emergency care, regardless of their insurance status or other personal characteristics. If an emergency medical condition is found to exist, the hospital must provide whatever treatment is necessary to stabilize that condition. A hospital may not transfer a patient in unstabilized emergency condition to another facility unless the medical benefits of the transfer outweigh the risks, and the transfer conforms to all applicable requirements. When emergency services are provided to an enrollee of the Contractor, the organization's liability for payment is determined as follows:

a. **Presence of a Clinical Emergency** - If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition exists, the Contractor must pay for both the services involved in the screening examination and the services required to stabilize the patient.

b. **Post Stabilization Care -** Emergency Services Continue Until the Patient Can be Safely Discharged or Transferred - The Contractor shall pay for all emergency services which are medically necessary until the clinical emergency is stabilized. This shall include payment for all treatment that may be necessary to assure, within reasonable medical probability, that no material deterioration of the patient's condition is likely to result from, or occur during, discharge of the patient or transfer of the patient to another facility.

If there is a disagreement between a hospital and the Contractor concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the enrollee at the treating facility prevails and is binding on the Contractor. The Contractor may establish arrangements with hospitals whereby the Contractor may send one of its own

physicians with appropriate ER privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the patient.

Post stabilization services are services subsequent to an emergency that a treating physician views as medically necessary AFTER an emergency medical condition has been stabilized.

The Contractor must cover the following services without requiring authorization, and regardless of whether the enrollee obtains the services within or outside the Contractor's network.

Post stabilization care services that were preapproved by the Contractor, or were not preapproved by the Contractor because the Contractor did not respond to the provider of post-stabilization care services request for pre-approval within one (1) hour after being requested to approve such care, or could not be contacted for pre-approval.

c. **Absence of a Clinical Emergency** - If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, the Contractor shall pay for all services involved in the screening examination if the presenting symptoms (including severe pain) were of sufficient severity to have warranted emergency attention under the "prudent layperson" standard, as defined herein. If an enrollee believes that a claim for emergency services has been inappropriately denied by the Contractor, the enrollee may seek recourse through the MCO or the State's designated external review organization appeal process.

d. **Referrals** - When an enrollee's primary care physician or other plan representative instructs the enrollee to seek emergency care in-network or out-of-network, the MCO shall be responsible for payment for the medical screening examination and for other medically necessary emergency services, without regard to whether the patient meets the "prudent layperson" standard, as defined herein.

The Contractor shall cover those medical examinations performed in emergency departments for enrolled children as part of a child protective services investigation. The Contractor may require that continuing care following the conclusion of an emergency, be obtained from a network provider or another health care provider specified by the Contractor. An emergency shall be deemed to have concluded at such time as the enrollee can, without medically harmful consequences, travel or be transported to an appropriate Contractor facility or to such other facility as the Contractor may designate.

9. Family Planning Services and Supplies

The Contractor shall cover all family planning services, which includes services, and drugs and devices for individuals of childbearing age, which delay or prevent pregnancy,

but does not include services to treat infertility or to promote fertility. FAMIS covered services include drugs and devices provided under the supervision of an in network physician.

Code of Virginia § 54.1-2969 (D), as amended, states that minors are deemed adults for the purpose of consenting to medical services required in case of birth control, pregnancy or family planning, except for purposes of sexual sterilization.

The MCO may not restrict an enrollee's choice of provider for family planning services or supplies, and the MCO is required to cover all family planning services and drugs and devices provided to its enrollees by network providers. The Contractor also allow the recipient, free from coercion or mental pressure, the freedom to choose the method of family planning to be used.

10. Hearing Aids

The Contractor shall cover hearing aides as outlined under Durable Medical Equipment. Hearing aides shall be covered twice every five years.

11. Home Health Services

The Contractor shall cover home health services, including nursing and personal care services, home health aide services, physical therapy, occupational therapy, speech, hearing and inhalation therapy up to 90 visits per calendar year. Personal care means assistance with walking, taking a bath, dressing, giving medicine, teaching self-help skills, and performing a few essential housekeeping tasks. The Contractor is not required to cover the following home health services: medical social services, services that would not be paid for by FAMIS if provided to an inpatient of a hospital, community food service delivery arrangements, domestic or housekeeping services which are unrelated to patient care, custodial care which is patient care that primarily requires protective services rather than definitive medical and skilled nursing care services, and services related to cosmetic surgery. Visits by a licensed nurse and home health aide services shall be covered as medically necessary. Rehabilitation services (physical therapy, occupational therapy, and speech-language therapy) shall also be covered under the enrollee's home
health benefit.

12. Hospice Services

The Contractor shall cover hospice care services to include a program of home and inpatient care provided directly by or under the direction a licensed hospice. Hospice care programs include palliative and supportive physician, psychological, psychosocial, and other health services to individuals utilizing a medically directed interdisciplinary tem. Hospice care services must be prescribed by a provider licensed to do so, furnished and billed by a licensed hospice, and medically necessary. Hospice care services are

available if the enrollee is diagnosed with a terminal illness with a life expectancy of six months or fewer.

13. Inpatient Hospital Services

The Contractor shall cover inpatient hospital stays in general acute care and rehabilitation hospitals for all enrollees up to 365 days per confinement in a semi-private room or intensive care unit for the care of illness, injury, or pregnancy (includes medically necessary ancillary services). The Contractor shall cover alternative treatment plan for a patient who would otherwise require more expensive services, including, but not limited to, long-term inpatient care. The Contractor must approve in advance the alternative treatment plan.

14. Inpatient Mental Health Services

Inpatient mental health services are covered for up to 30 days per calendar year, including partial day treatment services. Inpatient hospital MH services may include room, meals, general-nursing services, prescribed drugs, and ER services leading directly to admission. Inpatient and outpatient services may include diagnostic services; mental health services including: detoxification, individual psychotherapy, group psychotherapy psychological testing, counseling with family members to assist in the patient's treatment and electroconvulsive therapy.

Medically necessary inpatient psychiatric services rendered in a psychiatric unit of a general acute care hospital shall be covered for all FAMIS enrollees within the limits of coverage prescribed in the FAMIS plan and State regulations. The Contractor may cover freestanding psychiatric hospital admissions as an enhanced benefit.

All inpatient mental health admissions for individuals of any age to general acute care hospitals shall be approved by the Contractor using its own prior authorization criteria.

15. Inpatient Rehabilitation Hospitals

The Contractor shall cover inpatient rehabilitation services in facilities certified as rehabilitation hospitals and which have been certified by the Department of Health.

16. Inpatient Substance Abuse Services

Inpatient substance abuse services in a substance abuse treatment facility are covered for up to 90 days per enrollee (maximum lifetime benefit).

17. Laboratory and X-Ray Services

The Contractor shall cover all laboratory and x-ray services ordered, prescribed and directed or performed within the scope of the license of a practitioner in appropriate settings, including physician office, hospital, independent and clinical reference labs. All

laboratory testing sites providing services under this Contract must have Clinical Laboratory Improvement Amendments (CLIA) certification and either a clinical laboratory license, a certification of waiver, or a certificate of registration and an identification number. Those laboratories with certificates of waiver will provide only the types of tests permitted under the terms of the waiver. Laboratories with certificates of registration may perform the full range of services for which they are certified. No co-pay shall be charged for a laboratory or x-ray services that are performed as part of an encounter with a physician.

18. Medical Transportation

Transportation services are not provided for routine access to and from providers of covered medical services. Professional ambulance services when medically necessary are covered when used locally or from a covered facility or provider office. This includes ambulance services for transportation between local hospitals when medically necessary; if prearranged by the Primary Care Physician and authorized by the MCO if, because of the enrollee's medical condition, the enrollee cannot ride safely in a car when going to the provider's offices or to the outpatient department of the hospital. Ambulance services will be covered if the enrollee's condition suddenly because worse and must go to a local hospital's emergency room. For coverage of ambulance services, the trip to the facility or office must be to the nearest one recognized by the MCO as having services adequate to treat the enrollee's condition; the services received in that facility or provider's office must be covered services; and if the MCO or the Department requests it, the attending provider must explain why the enrollee could not have been transported in a private car or by any other less expensive means.

19. Organ Transplants

The Contractor shall cover organ transplantation services as medically necessary for all eligible individuals, to include transplants of tissues, autologous, allogeneic or synegenic bone marrow transplants or other forms of stem cell rescue for children with lymphoma and myeloma. The Contractor shall cover kidney transplants for patients with dialysis dependent kidney failure, heart, liver, and single lung transplants. The Contractor is not required to cover transplant procedures determined to be experimental or investigational. However, scheduled transplantations authorized by DMAS must be honored by the Contractor.

20. Outpatient Hospital Services

The Contractor shall cover outpatient hospital services which are preventive, diagnostic, therapeutic, rehabilitative or palliative in nature that are furnished to outpatients, and are furnished by an institution that is licensed or formally approved as a hospital by an officially designated authority for State standard-setting. Observation bed services shall be covered when they are reasonable and necessary to evaluate a medical condition to determine appropriate level of treatment or non-routine observation for underlying

medical complications. Outpatient services include emergency services, surgical services, diagnostic, and professional provider services. Facility charges are also covered.

21. Outpatient Mental Health and Substance Abuse Services

The Contractor is responsible for covering outpatient mental health clinic services and outpatient substance abuse services. Psychiatric and substance abuse services are limited to no more than a combined total of 50 medically necessary visits for treatment with a licensed mental health professional each calendar year. Inpatient and outpatient services may include diagnostic services; mental health services including: detoxification, individual psychotherapy, group psychotherapy psychological testing, counseling with family members to assist in the patient's treatment and electroconvulsive therapy. Medication management visits are not to be counted against the number of outpatient psychiatric visits.

The Contractor shall cover outpatient substance abuse services up to 50 medically necessary visits with a licensed mental health or substance abuse professional each calendar year.

22. Outpatient Prescription Drugs

The Contractor shall be responsible for covering all medically necessary drugs for its enrollees that by Federal or State law requires a prescription and in accordance with § 38.2-4312.1 of the Code of Virginia. The Contractor shall cover all FAMIS covered prescription drugs prescribed by providers licensed and/or certified as having authority to prescribe the drug. The Contractor is not required to cover Drug Efficacy Study Implementation (DESI) drugs or over the counter prescriptions. The Contractor shall cover therapeutic drugs even when they are prescribed as a result of carved-out services.

The Contractor may establish a formulary, may require prior authorization on certain medications, and may implement a mandatory generic substitution program. However, the Contractor shall have in place special authorization procedures to allow providers to access drugs outside of this formulary, if medically necessary. The MCO shall establish policies and procedures to allow providers to request a brand name drug for an enrollee if it is medically necessary. If a formulary is in place, in accordance with NCQA, the Contractor is required to notify those members who are affected by any product withdrawal, as well as notify the practitioner who prescribed the product. The Contractor shall not cover prescriptions for erectile dysfunction medication. The Contractor shall cover atypical antipsychotic medications developed for the treatment of schizophrenia. The Contractor shall ensure appropriate access to the most effective means to treat, except where indicated for the safety of the patient.

23. Physical Therapy, Occupational Therapy and Speech-Language Pathology and Audiology Services

The Contractor shall cover therapy services that are medically necessary to treat or promote recovery from an illness or injury, to include physical therapy, occupational therapy, speech therapy, inhalation therapy, intravenous therapy. The Contractor shall not be required to cover those school health services rendered by a school health clinic (See Attachment I for the definition of school health services).

24. Physician Services

The Contractor shall cover all symptomatic visits provided by physicians or physician extenders within the scope of their licenses. Cosmetic services are not covered unless performed for medically necessary physiological reasons. Cosmetic services are not covered except to correct deformity resulting from disease, trauma or congenital abnormalities, which cause functional impairment, or complete a therapeutic treatment as a result of such deformity. To determine if the service is cosmetic or not, the MCO shall not take into account the member's mental state. Physician services include services while admitted in the hospital, outpatient hospital departments, in a clinic setting, or in a physician's office.

25. Private Duty Nursing

The Contractor shall cover private duty nursing services only if the services are provided by a Registered Nurse, (RN) or a Licensed Practical Nurse (LPN); must be medically necessary; the nurse may not be a relative or member of the enrollee's family; the enrollee's provider must explain why the services are required; and the enrollee's provider must describe the medically skilled service provided. Private duty nursing services must be pre-authorized.

26. Prosthetic/Orthotic Services

The Contractor shall cover prosthetic services and devices (at minimum, artificial arms, legs and their necessary supportive attachments) for all enrollees. At a minimum, the Contractor shall cover medically necessary orthotics (i.e., braces, splints, ankle, foot orthoses, etc.) for enrollees. The Contractor shall cover medically necessary orthotics for enrollees when recommended as part of an approved intensive rehabilitation program.

27. Psychiatric Hospitals

The Contractor shall not cover any services rendered in freestanding psychiatric hospitals to enrollees up to nineteen (19) years of age. Medically necessary inpatient psychiatric services rendered in a psychiatric unit of a general acute care hospital shall be covered for all FAMIS enrollees within the limits of coverage prescribed in the FAMIS plan and State regulations.

All inpatient mental health admissions for enrollees to general acute care hospitals shall be approved by the Contractor using its own prior authorization criteria.

The Contractor may authorize admission to a freestanding psychiatric hospital as an enhanced service/benefit to enrollees in accordance with the Contractor's overall mental health protocols, policies, and network requirements.

28. Routine Childhood Immunizations

The Contractor shall ensure that providers render immunizations, in accordance with the most current Advisory Committee on Immunization Practices (ACIP) or American Academy pf Pediatric Advisory Committees for children under age six (6). The following additional immunizations are covered for enrollees age six and over: Influenza, Pneumonia, Chicken Pox, Tetanus Booster, and Hepatitis B. *HPV shall be covered for eligible females.*

The Contractor shall report annually to DMAS in accordance with HEDIS the percent of two-year-old FAMIS enrollees who have received each immunization specified in the most recent ACIP standards.

The Contractor is responsible for educating providers, parents and guardians of enrollees about immunization services, and coordinating information regarding enrollee immunizations.

FAMIS eligible enrollees shall not qualify for the Free Vaccines for Children Program.

To the extent possible, and as permitted by Virginia statute and regulations, the Contractor and its network of providers shall participate in the state-wide immunization registry database, when it becomes fully operational.

29. Second Opinions

The Contractor shall provide coverage for second opinions when requested by the enrollee for the purpose of diagnosing an illness and/or confirming a treatment pattern of care. The Contractor must provide for second opinions from a qualified health care professional within the network, or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee. The Contractor may require an authorization to receive specialty care for an appropriate provider; however, cannot deny a second opinion request as a non-covered service.

30. Skilled Nursing Facility Services

The Contractor shall cover medically necessary services that are provided in a skilled nursing facility for up to 180 days per confinement.

31. Telemedicine Services

The Contractor shall provide coverage for telemedicine services at least to the extent covered by the Department. Telemedicine is defined as the real time or near real time

two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment. The Department recognizes physicians, nurse practitioners, nurse midwives, clinical nurse specialists-psychiatric, clinical psychologists, clinical social workers, licensed and professional counselors for medical telemedicine services and requires one of these types of providers at the main (hub) satellite (spoke) sites for a telemedicine service to be reimbursed. Federal and State laws and regulations apply, including laws that prohibit debarred or suspended providers from participating in the Medicaid program. All telemedicine activities shall be compliant with HIPAA requirements. The following tables detail the specific services and procedure codes utilized by the Department in relation to coverage for telemedicine.

Telemedicine Services and Procedure Codes

Hub Site Provider Description of Service	**CPT Code**	**Modifier**
Consultation	99241-99275	GT
Office visits	99201-99215	GT
Individual psychotherapy	90804-90809	GT
Pharmacological management	90862	GT
Colposcopy	57452,57454,57460	GT
Obstetric Ultrasound	76805,76810	GT
Cardiography interpretation and report only	93010	GT
Echocardiography	99307,99308,99320,99321, 33925	GT
Distance or "Spoke" Site Provider Description of Service	**HCPCS Code**	**Modifier**
Telehealth originating site facility fee	Q3014	GT
If a higher-level service is medically necessary DMAS requires the provider to use the most appropriate CPT code, as listed in the "Hub Site" section above.	See above.	GT

32. Therapy Services

The Contractor shall cover the costs of renal dialysis, chemotherapy and radiation therapy, intravenous, and inhalation therapy.

33. Vision Services

The Contractor shall cover vision services that are defined as diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians. Routine refractions shall be allowed at least once in twenty-four (24) months. Routine eye examinations, for all enrollees, shall be allowed at least once every two (2) years. The Contractor shall cover eyeglasses (one pair of frames and one pair of lenses) or contact lenses prescribed as medically necessary by a physician skilled in diseases of the eye or by an optometrist for enrollees.

The enrollee co-payment level for routine eye exams shall be $2.00 for ≤ 150% FPL and $5.00 for >150% FPL. The health plan's reimbursement level for frames and lenses is:

- Eyeglass frames (one pair) $25.00
- Eyeglass lenses (one pair)
  - single vision $35.00
  - bifocal $50.00
  - trifocal $88.50
  - contacts $100.00

34. Well Baby and Well Child Care

The Contractor shall cover routine well baby and well childcare including routine office visits with health assessments and physical exams, as well as routine lab work and age appropriate immunizations.

The following services rendered for the routine care of a well child:

Laboratory services: blood lead testing, HGB, HCT or FEP (maximum of 2, any combination); Tuberculin test (maximum of 3 covered); Urinalysis (maximum of 2 covered); Pure tone audiogram for age 3-5 (maximum of 1); Machine vision test (maximum of 1 covered).

Well child visits rendered at home, office and other outpatient provider locations are covered at birth and months 1, 2, 4, 6, 9, 12, 15, 18 and covered at ages 2, 3, 4, 5, 6, 8, 10, 12, 14, 16, 18.

The Contractor shall allow for an annual flu vaccine without limitations to age and without the requirement of meeting the CDC at risk guidelines.

Hearing Services

All newborn infants will be given a hearing screening before discharge from the hospital after birth. Those children who did not pass the newborn hearing screening, those who were missed, and those who are at risk for potential hearing loss should be scheduled for evaluation by a licensed audiologist.

Periodic auditory assessments appropriate to age, health history and risk, which include assessments by observation (subjective) and/or standardized tests (objective). At a minimum, these services shall include diagnosis of and treatment for defects in hearing, including hearing aids.

35. Women's Health Care Services

a. The Contractor shall permit any female enrollee of age thirteen (13) or older direct access to a participating obstetrician-gynecologist for annual examinations and routine health care services including pap smears without prior authorization from the primary care physician. Health care services means the full scope of medically necessary services provided by the obstetrician-gynecologist in the care of or related to the female reproductive system in accordance with the most current published recommendations of the American College of Obstetricians and Gynecologists.

b. The Contractor shall cover mammograms for female enrollees as medically appropriate.

c. The Contractor shall cover services to pregnant women, including prenatal services. For prenatal services, the co-pay applies to the first visit only.

36. FAMIS Carved-Out Services

The Contractor is not required to cover dental services, school health services for special education students that include physical therapy, occupational therapy, speech language pathology, skilled nursing services, or community rehabilitation mental health services and mental retardation services, including intensive in-home services, case management services, day treatment, and 24-hour emergency response. The Department will reimburse these services. The Department's Dental Benefits Administrator will reimburse dental services.

The Contractor shall cover therapeutic drugs even when they are prescribed as a result of carved-out services.

37. Coverage of Prior Authorized Services

a. The Contractor (the enrollee's current MCO) shall assume responsibility for managed care contract services authorized by either the Department or a previous MCO, which are rendered after the enrollment effective date, in the absence of a written agreement otherwise. The Contractor shall allow their new enrollees who are transitioning from fee-for-service to receive services from out-of-network providers if the enrollee contacts the Contractor in advance of the service date and the enrollee has an appointment(s) within the initial month of enrollment with a specialty physician(s) that was scheduled prior to the effective date of membership. For on-going services, such as home health, outpatient mental health, and outpatient rehabilitation therapies, etc., the Contractor (the enrollee's current MCO) shall continue prior authorized services without interruption, until the Contractor completes its utilization review process

to determine medical necessity of continued services or to transition services to a network provider.

b. If services have been pre-authorized using a provider who is out of network, the Contractor may elect to re-authorize (but not deny) those services using an in-network provider.

38. Out-of-Network Services

a. The Contractor shall cover, pay for and coordinate care, when feasible, rendered to enrollees by out-of-network providers when the enrollee is given emergency treatment by such providers outside of the service area, subject to the conditions set forth elsewhere in this Contract.

b. The Contractor shall cover and pay for services furnished in facilities or by

practitioners outside the Contractor's network if the needed medical services or necessary supplementary resources are not available in the Contractor's network.

c. To ensure against adverse disenrollment, the MCO must provide coverage out-of-network for any of the following circumstances:

1. When a service or type of provider is not available within the MCO's network or where the MCO cannot provide the needed specialist within the contract distance standard of more than 30 miles in urban areas or more than 60 miles in rural areas.

2. For up to 30 days to transition the client to an in-network provider, when a provider that is not part of the MCO's network has an existing relationship with the beneficiary, is the beneficiary's main source of care, and has not accepted an offer to participate in the MCO's network.

3. When the providers that are available in the MCO's network do not, because of moral or religious objections, furnish the service the client seeks.

4. When DMAS determines that the circumstance warrants out-of-network treatment.

d. The Contractor is not responsible for services obtained outside the state unless they are emergency services or post-stabilization services. The Contractor shall cover services outside the state if services are needed because of a medical emergency, because the enrollee's health would be endangered if he were required to travel back to his state, if the

Department determines the needed services are more readily available in another state, or if it is a general practice for enrollees in a particular locality to use medical resources in another state. If an enrollee goes out of state for non-emergency services (including urgent services) that are not authorized by the Contractor in advance of the service, other than as described above, the Contractor is not responsible.

39. Modification in Scope of Covered Services

The Department, at its sole discretion, may reduce, increase, or otherwise modify covered services required by this Contract. If appropriate, the Department shall modify the capitation payment in an amount deemed, in the sole opinion of the Department, to be appropriate. The Department shall notify the Contractor in advance of any modification to the capitation payment. Should the Contractor be unable or unwilling to provide the increased, reduced, or modified covered services at the capitation rate provided by the Department, the Contract may be terminated by the Contractor following the termination procedures specified elsewhere in this contract.

40. Cost Sharing

FAMIS enrollees will be subject to cost sharing provisions that will include nominal co-payments for services rendered.

No cost sharing shall be imposed on American Indians and Alaska Natives.

Once the Department identifies these American Indian and Alaska Native enrollees, the information will be transmitted to the MCO. The MCO must ensure that the enrollee receives an appropriate identification card, i.e. indicating $0 co-payments. The MCO must provide assurances that co-payments are not charged to American Indians and Alaska Natives.

Under FAMIS, total cost sharing is limited to 2.5% of gross income for families with incomes below 150% of the federal poverty level (FPL), and to 5% of income for families with incomes between 150% and 200% of the FPL. Families below 150% of FPL are responsible for co-payments, which are currently capped at $180 per family per calendar year. Families with incomes between 150% and 200% of the FPL co-payments are capped at $350 per family per year. See Attachment II.

Each FAMIS family will be responsible for keeping track of the total amount of co-payments made by each family. The Department's designated agent shall verify family information and maintain a list of families that have reached the maximum family co-payment for a 12-month period to be defined by DMAS. Once a family has reached their maximum annual cost share level the Department's designated agent will be responsible for ensuring that all interested parties are apprised of the fact that additional co-pays cannot be levied.

The Contractor shall be responsible for developing a mechanism to stop collecting co-payments once notified by the Department's designated agent. The Contractor must be able to receive co-payment information from the Department or its designated agent.

41. Enhanced Services

Enhanced services are those services that are offered by the Contractor to enrollees in excess of FAMIS covered services, with exceptions. The Contractor must implement co-payments as stated in the above section on Cost-Sharing. The Contractor shall not override Federal requirements on freestanding psychiatric admissions. Nothing in this Contract shall preclude the Contractor from providing additional health care health improvement services or other services not specified in this Contract, including admission to a free-standing psychiatric hospital as long as these services are available, as needed or desired, to enrollees. No increased reimbursement will be made for additional services provided by the Contractor under this Contract. The Contractor must inform the Department at least thirty (30) calendar days prior to implementing, revising or removing any enhanced services. The contractor must report annually the enhanced services it offers. Additionally, the Contractor must be able to provide to the Department, upon request, data summarizing the utilization of enhanced services provided to enrollees during the contract year for rate setting purposes. Enhanced services for psychiatric care provided in a free-standing psychiatric hospital may not be used to substitute for state plan covered services.

42. State Laws and Regulations Governing the Provision of Medical Services

The MCO shall be required to comply with all State laws and regulations, including but not limited to: (1) the *Code of Virginia* Ann. Title 38.2, Chapter 43, as amended; (2) Rules Governing Health Maintenance Organizations, Virginia Administrative Code, Title 14, as amended, Chapter 5-210.

43. Medical Necessity

The Contractor shall cover medically necessary services, as defined in Article I of this Contract and the Family Access to Medical Insurance Security Plan (FAMIS) as amended and as further defined by written Department policies (including agreements, statements, provider manuals, FAMIS memorandums, instructions, or memoranda of understanding) and all applicable State and Federal regulations, guidelines, transmittals, and procedures. The actual provision of any service is subject to the professional judgment of the Contractor's providers as to the medical necessity of the service, except in situations in which the Contractor must provide services ordered by the Department pursuant to an appeal from the Contractor's grievance process or an appeal directly to the Department by the parent or guardian of an enrollee or for emergency services as defined in this Contract. Decisions to provide authorized medical services required by this Contract shall be based solely on medical necessity and appropriateness. Disputes between the Contractor and enrollees about medical necessity may be appealed to the

external review organization by the enrollee or the enrollee's representative after completing the Contractor's appeal process.

44. FAMIS MOMS Covered Services

The Contractor shall provide, arrange for, purchase or otherwise make available the full scope of FAMIS MOMS services. Benefits available to recipients covered by FAMIS MOMS are the same as those available in Medallion II. FAMIS Moms shall have no cost sharing for the services they receive while enrolled.

In no case shall the Contractor establish more restrictive benefit limits for medically necessary services than those established by Medicaid. The Contractor shall manage service utilization through utilization review and prior authorization, but not through the establishment of benefit limits for medically necessary services that are more restrictive than those established by Medicaid. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Coverage decisions that depend upon prior authorization and/or concurrent review to determine medical necessity must be supervised by qualified medical professionals and completed within a reasonable period of time after receipt of all necessary information. The Contractor shall assume responsibility for all covered medical conditions of each enrollee as of the effective date of coverage under the Contract, regardless of the date on which the condition arose. The Contractor shall cover all pre-existing conditions.

45. FAMIS Contractor Referral Responsibilities

The Contractor shall advise the enrollees of the availability of services offered by the following programs, if appropriate to address the needs of the enrollee. The Contractor will coordinate with and refer enrollees to the following programs:

(1) Prior Authorization (PA)

The Contractor shall refer enrollees to the Department's PA contractor, as needed.

(2) Lead Environmental Investigation

The Contractor shall refer individuals who require a lead environmental investigation to the local health department for assistance.

H. MEMBER SERVICES

1. The Contractor agrees to maintain and staff a toll-free Member or Customer Services function to be operated at least during regular business hours and to be responsible for the following:

a. Explaining the operation of the MCO, including the role of the PCP and what to do in an emergency or urgent medical situation;

b. Assisting enrollees in the selection of a PCP;

c. Assisting enrollees to make appointments and obtain services; and

d. Handling enrollee complaints.

2. The Contractor shall comply with industry specific standards for ensuring acceptable levels of service for:

a. Waiting/Hold Times
b. Abandonment Rate

I. PROVIDER NETWORK COMPOSITION AND ACCESS TO CARE STANDARDS

The Contractor shall maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under this Contract. The Contractor shall meet the following network and access standards:

1. Network Provider Composition

a. The Contractor shall be solely responsible for arranging for and administering covered services to enrollees and must ensure that its delivery system will provide available, accessible and adequate numbers of facilities, locations and personnel for the provision of covered services. The Contractor shall include in its network or otherwise arrange care by providers specializing in early childhood, youth services. In establishing and maintaining the network, the Contractor shall consider all of the following:

i. the anticipated FAMIS enrollment;

ii. the expected utilization of services, taking into consideration the characteristics and health care needs of the anticipated FAMIS population to be served;

iii. the numbers and types (in terms of training and experience, and specialization) of providers required to furnish the contracted services;

iv. the numbers of network providers not accepting new FAMIS patients; and

v. the geographic location of providers and FAMIS enrollees, considering distance, and travel time.

b. The Contractor shall notify the Department within thirty (30) business days of any changes to a network provider agreement made by the Contractor, a subcontractor, or network provider regarding termination, pending termination, or pending modification in the subcontractor's or network provider's terms and not otherwise addressed in Attachment IV, Section C, that could materially reduce FAMIS enrollee access to care. The Contractor shall notify the Department where it experiences difficulty in contracting or re-contracting with hospitals or hospital systems. This written notice must occur in advance of the formal notification of hospital's termination from the Contractor's network.

c. Any physician who provides inpatient services to the Contractor's enrollees shall have admitting and treatment privileges in a minimum of one general acute care hospital that is in the Contractor's network and is located within the contract service area.

d. The Contractor shall submit to the Department and its designated agent a complete provider file (see Attachment III). The file shall be in a Department approved electronic format. The provider file shall be submitted thirty (30) days prior to the effective date of the Contract. An updated file with all of the changes to the network will be submitted monthly thereafter to the designated agent. The Contractor shall submit to the Department complete provider files quarterly. Additional required elements to be included in this report may be identified by the Department.

e. The Department or its designated agent shall work with participating MCOs to secure source data that will populate the electronic provider database (Attachment III). At a minimum, the database shall include the name, office telephone number, office address and specialty of participating providers. As available, the database shall also include each provider's panel size, office hours, language(s) spoken and special requirements or services (e.g., populations served). DMAS will facilitate the provision of such data, as necessary.

Network provider composition standards set forth in this article are not the minimum standards for network development for entry into new or existing managed markets. These standards shall be considered as operational guidelines. The Department shall be the sole determiner of Contractor network sufficiency. Additional network and expansion requirements are set forth in Attachment XIX, DMAS Managed Care Expansion Requirements. Attachment XIX details notification and expansion requirements required by the Department to assure that

appropriate IT, network development, budget and personnel resources are available for introducing managed care into new areas. Plans must provide at least 12 months verbal notice and 6 months written notice to the Department when seeking entry into new managed care areas.

2. Network Provider Licensing and Certification Standards

Each Contractor must have the ability to determine whether physicians and other health care professionals are licensed by the State and have received proper certification or training to perform medical and clinical services contracted for under this Contract. The Contractor's standards for licensure and certification shall be included in its participating provider network agreements with its network providers, which must be secured by current subcontracts or employment contracts.

The Contractor will ensure that it makes its best effort that as part of its credentialing process all providers, including ancillary providers, (i.e. vision, pharmacy, etc.), apply for enrollment in the Medicaid program.

3. Enrollee-to-PCP Ratios

As a means of measuring accessibility, the Contractor must have at least one (1) full-time equivalent (FTE) pediatric PCP, for every 1,500 FAMIS enrollees, and there must be one (1) FTE PCP with pediatric training and/or experience for every 2,500 enrollees under the age of eighteen (18). No PCP may be assigned enrollees in excess of these limits, except where mid-level practitioners are used to support the PCP's practice.

When specialists act as PCPs, the duties they perform must be within the scope of their specialist's license.

4. Specialist Services

The Contractor shall maintain an adequate pediatric specialist network and a referral listing.

5. Inpatient Hospital Access

The Contractor shall maintain in its network a sufficient number of inpatient hospital facilities, which is adequate to provide covered services to its enrollees. The Contractor shall notify the Department within fifteen (15) calendar days of any changes to its contracts with hospitals if those changes impact the scope of covered services, the number of individuals covered and/or the units of service covered.

6. Policy of Nondiscrimination

The Contractor shall ensure that its providers provide contract services to enrollees under this Contract in the same manner as they provide those services to all non-FAMIS enrollees. The Contractor shall ensure that its network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees.

7. Twenty-Four Hour Coverage

The Contractor shall maintain adequate provider network coverage to serve the entire eligible FAMIS populations in geographically accessible locations within the region twenty-four (24) hours per day, seven (7) days a week. The Contractor shall make arrangements to refer patients seeking care after regular business hours to a covering physician or shall direct the enrollee to go to the emergency room when a covering physician is not available. Such referrals may be made via a recorded message.

In accordance with the *Code of Virginia* § 38.2 - 4312.3 as amended, the Contractor shall maintain after-hours telephone service, staffed by appropriate medical personnel, which includes access to a physician on call, a primary care physician, or a member of a physician group for the purpose of rendering medical advice, determining the need for emergency and other after-hours services, authorizing care, and verifying enrollee enrollment with the Contractor.

8. Travel Time and Distance

a. Travel Time Standard

The Contractor shall ensure that each enrollee shall have a choice of at least two (2) PCPs located within no more than thirty (30) minutes travel time from any enrollee unless the Contractor has a Department-approved alternative time standard. Travel time shall be determined based on driving during normal traffic conditions (i.e., not during commuting hours). The Contractor shall ensure that obstetrical services are available within no more than forty-five (45) minutes travel time from any pregnant enrollee unless the Contractor has a Department approved alternative time standard.

b. Travel Distance Standard

The Contractor shall ensure that each enrollee shall have a choice of at least two (2) PCPs located within no more than a fifteen (15) mile radius in urban areas and thirty (30) miles in rural areas unless the Contractor has a Department-approved alternative distance standard. The Contractor must ensure that an enrollee is not required to travel in excess of thirty (30) miles in an urban area and sixty (60) miles in a rural area to receive services from specialists, hospitals, special hospitals, psychiatric hospitals, diagnostic and therapeutic services, and physicians, or other necessary providers, unless the enrollee so chooses. An exception to this standard may be granted when the Contractor has established, through utilization data provided to the Department, that a normal pattern for

securing health care services within an area falls beyond the prescribed travel distance or the Contractor and its PCPs are providing a higher skill level or specialty of service that is unavailable within the service area, such as treatment of cancer, burns, or cardiac diseases.

9. Appointment Standards

a. The Contractor must arrange to provide care according to each of the following appointment standards:

i. Appointments for emergency services shall be made available immediately upon the enrollee's request.

ii. Appointments for an urgent medical condition shall be made within twenty-four (24) hours of the enrollee's request.

iii. Appointments for routine care shall be made within two weeks of the enrollee's request. This standard does not apply to appointments for routine physical examinations, nor for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) days.

iv. The enrollee cannot be billed for missed appointments.

b. For maternity care, the Contractor shall be able to provide initial prenatal care appointments for pregnant enrollees as follows:

i. First trimester - within fourteen (14) calendar days of request

ii. Second trimester - within seven (7) calendar days of request

iii. Third trimester and high-risk pregnancies- within three (3) business days of request

10. Emergency Services Coverage

The Contractor shall ensure that all emergency FAMIS covered services are available twenty-four (24) hours a day, seven (7) days a week.

11. Assurances that Access Standards Are Being Met

The Contractor must establish a system to monitor its provider network to ensure that the access standards set forth in this Contract are met; must monitor regularly to determine compliance, take corrective action when there is a failure to comply, and must be prepared to demonstrate to the Department that these access standards have been met.

J. NETWORK ADMINISTRATION

1. Provider Enrollment

a. Contractor shall provide adequate resources to support a provider relations function that will effectively communicate with existing and potential network providers. The Contractor shall provide this information to potential network providers upon request. The Contractor's network provider agreement shall comply with the terms set for in Attachment IV.

b. The Contractor shall not require as a condition of participation/contracting with physicians in their FAMIS managed care network to also participate in the Contractor's commercial managed care network.. This provision would not preclude a Contractor from requiring their commercial network providers to participate in their FAMIS provider network.

2. Antidiscrimination

Pursuant to Section 1932 (b)(7) of the SSA, the Contractor shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. Additionally, provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This section shall not be construed to prohibit the Contractor from including providers only to the extent necessary to meet the needs of the organization's enrollees; or from using different reimbursement amounts; or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the Contractor.

3. Provider Education

The Contractor shall ensure that all providers receive proper education and training regarding the FAMIS managed care program to comply with this Contract and all applicable Federal and State requirements.

4. Provider Payment

In accordance with Section 1932(f) of the Social Security Act (42 U.S.C. §1396a-2) the Contractor shall pay all in-and out-of-network providers on a timely basis, consistent with the claims payment procedure described in 42 C.F.R. § 447.45, Section 1902 (a)(37), upon receipt of all clean claims for covered services rendered to covered enrollees who are enrolled with the Contractor. 42 C.F.R. § 447.45 defines timely processing of claims as:

a. Adjudication (pay or deny) of ninety per cent (90%) of all clean claims within thirty (30) days of the date of receipt.

b. Adjudication (pay or deny) of ninety-nine per cent (99%) of all clean claims within ninety (90) days of the date of receipt.

c. Adjudication (pay or deny) all other claims within twelve (12) months of the date of receipt. (See 42 C.F.R. §447.45 for timeframe exceptions)

This requirement shall not apply to network providers who are not paid by the Contractor on a fee-for-service basis and will not override any existing negotiated payment scheduled between the Contractor and its providers. This requirement applies to Virginia FAMIS clean claims.

The Contractor must make available to providers an electronic means of submitting claims. In addition, the Contractor shall make every effort to assure at least fifty (50%) percent of claims received from providers are submitted electronically.

The Contractor must pay interest charges on claims in compliance with requirements set forth in § 38.2-4306.1 of the Code of Virginia. Specifically interest upon the claim proceeds paid to the subscriber, claimant, or assignee entitled thereto shall be computed daily at the legal rate of interest from the date of thirty calendar days from the Contractor's receipt of "proof of loss" to the date of claim payment. "Proof of loss" means the date on which the Contractor has received all necessary documentation reasonably required by the Contractor to make a determination of benefit coverage. This requirement does not apply to claims for which payment has been or will be made directly to health care providers pursuant to a negotiated reimbursement arrangement requiring uniform or periodic interim payments to be applied against the health maintenance organization's obligation on such claims.

Under 1932 (b) the Contractor must establish an internal grievance procedure by which providers under contract may challenge the Contractor's decisions including but not limited to the denial of payment for services.

The Contractor shall notify the Department 45 days in advance of any proposal to modify claims operations and processing that shall include relocation of any claims processing operations. Any expenses incurred by the Department, its contractors, or providers to adapt to the Contractor's claims processing operational changes (including but not limited to costs for site visits) shall be borne by the Contractor.

To the extent the governor and/or General Assembly implement any rate adjustments for Medicaid/FAMIS services/providers, and these rate adjustments are incorporated into the FAMIS capitation payment rates during the contract period, the Contractor is required to reimburse these relevant services/providers at a level at least equal to the revised fee-for-service fees under the Medicaid fee schedule, beginning on the effective date of the rate adjustment, unless otherwise agreed to by the Department. The Contractor shall provide

written notice to providers in a format determined by the Contractor advising of the rate adjustment and when it shall be effective. A copy of such notification shall be provided to the Department before the Contractor's distribution of such notice.

5. Provider Disenrollment

The Contractor must have in place written policies and procedures which are filed annually and approved by the Department related to provider termination including procedures to provide a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of termination of a contracted provider, and within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from the terminated provider.

6. Ineligible Provider or Administrative Entities

The Contractor shall, upon obtaining information or receiving information from the Department or from another verifiable source, exclude from participation in the Contractor's plan for this Contract all provider or administrative entities which could be included in any of the following categories (references to the Act in this Section refer to the Social Security Act):

a. Entities which could be excluded under § 1128(b)(8), as amended, of the Social Security Act are entities in which a person who is an officer, director, or agent or managing employee of the entity, or a person who has direct or indirect ownership or control interest of five (5) percent or more in the entity has:

i. Been convicted of any of the following crimes:

1) Program related crimes, i.e., any criminal offense related to the delivery of an item or service under any Medicare, FAMIS, or other State health care program (as provided in § 1128(a)(1) of the Act, as amended);

2) Patient abuse, i.e., a criminal offense relating to abuse or neglect of a patient in connection with the delivery of a health care item or service (as provided in § 1128(a)(2) of the Act, as amended);

3) Fraud, i.e., a State or Federal crime involving fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care or involving an act or omission in a program operated by or financed in whole or part by Federal, State

or local government (as provided in § 1128(b)(1) of the Act), as amended;

4) Obstruction of an investigation, i.e., conviction under State or Federal law of interference or obstruction of any investigation into any criminal offense described in subsections of a. b. or c (as provided in § 1128(b)(2) of the Act, as amended); or

5) Offenses relating to controlled substances, i.e., conviction of a State or Federal crime relating to the manufacture, distribution, prescription or dispensing of a controlled substance (as provided in § 1128(b)(3) of the Act, as amended);

ii. Been excluded from participation in Medicare or a State health care program; or

iii. Been assessed a civil monetary penalty under Section 1128A of the Social Security Act (42 U.S.C. § 1320a-7(a)-(f). Civil monetary penalties can be imposed on an individual provider, as well as on provider organizations, agencies, or other entities, by the HHS Office of Inspector General, and may be imposed in the event of false or fraudulent submittal of claims for payment, and certain other violations of payment practice standards.

iv. Been debarred, suspended, or otherwise excluded from participation in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 and 45 CFR Part 76 or under guidelines implementing such an order or is an affiliate (as defined in such Act) of a person described in clause (a).

The Contractor shall immediately notify the Department of any action taken by the Contractor to exclude, based on the provisions of this section, an entity currently participating.

b. Entities that have a direct or indirect substantial contractual relationship with an individual or entity described in Paragraph 1, above. A substantial contractual relationship is defined as any contractual relationship that provides for one or more of the following services:

i. The administration, management, or provision of medical services;

ii. The establishment of policies pertaining to the administration, management, or provision of medical services; or

iii. The provision of operational support for the administration, management, or provision of medical services.

The Contractor attests by signing this Contract that it excludes from participation in the Contract activities all entities that could be included in the categories listed in b. i. through iii. above.

7. Physician Incentive Plan

In accordance with 42 C.F.R. § 434.70, the Contractor shall comply with 42 C.F.R. §§ 417.479(a) through (g) as amended, specifying the requirements for physician incentive plans. If the Contractor enters into subcontracting arrangements, it shall comply with 42 CFR § 417.479(i), as amended. If a physician financial arrangement is determined by the Department to potentially avoid costs by limiting referral specialty care for enrollees, the Contractor must demonstrate to the Department that all medically necessary referrals were authorized during the contract period. The Contractor is prohibited from making any payment under a PIP as an inducement to limit or reduce medically necessary services to an individual. The Physician Incentive Plan should be submitted annually to the Department using the CMS established form.

The Contractor shall report annually whether services not furnished by physician/group are covered by PIP or incentive arrangement that includes withhold, bonus, capitation, and percent of withhold or bonus, if applicable.

8. Protection of Enrollee-Provider Communications

The Contractor must not prohibit or restrict a health care professional from advising an enrollee about his or her health status, medical care, or treatment, regardless of whether benefits for such are provided under the Contract, if the provider is acting within the lawful scope of practice as described in Section 4704 (b)(3) of Public Law 105-33.

9. Protected Health Information

To the extent that the Contractor uses one or more providers to render services under this contract, and such providers receive or have access to the Protected Health Information (PHI), each such provider or agent shall sign an agreement with the Contractor that complies with HIPAA. The Contractor shall ensure that any providers to whom it provides PHI received from the Department (or created or received by the Contractor on behalf of the Department) agree in writing to the same restrictions, terms, and conditions relating to PHI that apply to the Contractor in this Contract.

10. Provider Inquiry Performance Standards

The Contractor shall answer telephonic provider inquiries, including requests for referrals and prior-authorizations with a monthly average speed of answer (ASA) of less than two (2) minutes. Provider call abandonment rates shall average less than 10% each month. The Contractor will provide a monthly report of these measures to the Department. Submission may include combined commercial and Medicaid business.

The Contractor's report details shall include Virginia business only. Submission of averages for all the Contractor's other non-Virginia business is not permissible.

11. Provider Advisory Committee

The Contractor shall establish and maintain a provider advisory committee, consisting of providers contracting with the Contractor to serve enrollees. At least two providers on the committee shall maintain practices that predominantly serve Medicaid recipients and other indigent populations, in addition to at least one other participating provider on the committee who has experience and expertise in serving enrollees with special needs. The committee shall meet at least quarterly and its input and recommendations shall be employed to inform and direct Contractor quality management and activities and policy and operations changes. The Department may conduct on-site reviews of the membership of this committee, as well as the committee's activities throughout the year.

12. Provider Satisfaction Survey

The Contractor shall conduct a bi-annual satisfaction survey of a statistically valid sample of its participating Medicaid providers. The Contractor shall submit a copy of the survey instrument and methodology to the Department. The Contractor shall communicate the findings of the survey to the Department in writing within one hundred twenty (120) days after conducting the survey. The written report shall also include identification of any corrective measures that need to be taken by the Contractor as a result of the findings, a time frame in which such corrective action will be taken by the Contractor and recommended changes as needed for subsequent use. . The first survey shall be completed during the 2007-2008 contract year. Results of the first survey shall be submitted no later than October 1, 2008, and bi-annually thereafter.

K. QUALITY IMPROVEMENT (QI)

The Contractor shall comply with 42 C.F.R. § 434.34, as amended, which requires each managed care organization that contracts with State Medicaid agencies to have an internal quality improvement program (QIP). Such QIP shall meet the accreditation standards of NCQA. The Contractor is encouraged to perform all HEDIS performance measures for the Medicaid product as a part of the QI Program.

The Contractor must have a program which focuses on prenatal care, the identification of individuals who may be pregnant, and the application of appropriate treatments for high-risk individuals. Program results must be reported annually to the Department.

In addition, the Contractor shall, at a minimum, complete all seven of the following HEDIS performance studies. The Contractor will assure annual improvement in its HEDIS scores until such time that the Contractor is performing at least the national average HEDIS benchmark. Thereafter, the Contractor is to sustain at the national average or increase its performance.

1. Childhood Immunization Status
2. Adolescent Immunization Status
3. Well-Child Visits in the First 15 Months of Life
4. Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life
5. Adolescent Well-Care Visits
6. Asthma-Appropriate Use of Medication
7. Diabetes

The Contractor shall send to the Department (annually) a copy of its clinical practice guidelines, its quality improvement program, and prior year's outcomes, including results of HEDIS, and other performance measures, quality studies, and other activities as documented in the QIP. The Contractor shall provide to DMAS separate reports for the following:

a. Children with asthma
b. Children with diabetes

In conducting HEDIS measures, the contractor shall use the hybrid methodology unless otherwise stated in HEDIS technical specification guidelines. The Contractor shall send to the Department (annually) a copy of its quality improvement program and prior year's outcomes, including HEDIS results, and other performance measures, quality studies, and other activities as documented in the QIP using the data submission tool. Results shall reflect completion dates.

With respect to HEDIS measures, areas in which the contractor's performance rates are below national Medicaid benchmarks or have decreased by more that five (5) percentage points, a corrective action plan must be submitted within 30 days following the submission of the annual HEDIS audit to the Department.

The Contractor's QIP shall consist of systematic activities to monitor and evaluate the care delivered to enrollees according to predetermined, objective standards and to make improvements as needed. The Contractor shall correct significant systematic problems that come to its attention through internal surveillance, complaints, or other mechanisms. The QIP shall illustrate a comprehensive, integrated approach that encompasses all aspects of the health care delivery system for FAMIS. The Contractor shall insure that their grievance system is tied to their quality improvement program.

The Contractor shall cooperate with the Department's QIP to the extent described herein and shall, upon request, demonstrate to the Department its degree of compliance with the Department's quality standards set forth below. Additionally, the Contractor and its subcontractors and its network providers shall cooperate with the Department or its designated agent in conducting quality reviews when so requested by the Department.

1. Quality Studies and Performance Measures

The Contractor shall cooperate with and ensure the cooperation of network providers and subcontractors with the external review organization contracted by the Department to perform quality studies including providing timely access to FAMIS enrollees' medical records in the Department's requested format. The Contractor shall submit annually and upon request to the Department results of their internal quality studies.

The Contractor shall report to DMAS annually the percentage of children who received all expected well-child care visits according to the benefit schedule, during the period that each child was enrolled. In addition, the Contractor will report annually the percentage of children who achieved the age of two years old during the period who received all immunizations recommended by the current ACIP guidelines. DMAS will provide specifications for calculating these measures.

The Contractor shall submit requested information by the due date provided by the EQRO or as communicated by the Department. If an extension is required, the request must be made by the Contractor to the Department at least one week prior to the requested due date.

2. Coordination and Continuity of Care

The Contractor shall have systems in place to ensure coordinated patient care. The systems, policies and procedures shall be consistent with the most recent NCQA standards.

3. Coordination of QI Activity with Other Management Activity

The Contractor's QI findings, conclusions, recommendations, actions taken, and results of the actions taken shall be documented and reported to appropriate individuals within the Contractor's management organization and through the established QI communication channels.

QI activities shall be coordinated with other performance monitoring activities, including the monitoring of enrollees' complaints, and shall reflect the most current standards of NCQA.

4. Utilization Management/Authorization Program Description

The Contractor must have a written utilization management (UM) program description which includes procedures to evaluate medical necessity, criteria used, information source, and the process used to review and approve or deny the provision of medical services. The Contractor's UM program must ensure consistent application of review criteria for authorization decisions; and consult with the requesting provider when appropriate. The program shall also include drug formulary decisions and criteria. The program shall demonstrate that enrollees have equitable access to care across the network and that UM decisions are made in a fair, impartial, and consistent manner that serves the best interest of the enrollees. The program shall reflect the standards for utilization management from the most current national Standards.

The program must have mechanisms to detect under-utilization and/or over-utilization of care, including, but not limited to, provider profiles. The Contractor shall work with the Department and the other contracted MCOs to establish review criteria and to study the scope of underutilization for children. The study shall be completed by February 1, 2005 and shall include the following components:

a. Identification of underutilization issues within the population.
b. A quality improvement strategy to address the identified issues for this population.
c. A mechanism for reporting results to the Department for the issues identified.

Coverage decisions that depend upon prior authorization and/or concurrent review to determine medical necessity must be supervised by qualified medical professionals and completed within two (2) days after receipt of all necessary information. The Contractor shall use Department prior authorization criteria or medically-sound, scientifically based criteria in accordance with NCQA standards in making medical necessity determinations. Medical necessity criteria used by the Contractor shall be treated by the Department as proprietary information of the Contractor and shall not be subject to disclosure by the Department.

Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease. Additionally the Contractor and its subcontractors are prohibited from providing compensation to UM staff in a manner so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

The following timeframe for decisions requirements apply to service authorization requests:

a. Standard Authorization Decisions – For standard authorization decisions, the contractor shall provide the decision notice as expeditiously as the enrollee's

health condition requires, not to exceed fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days if

i. the enrollee or the provider requests extension; or,
ii. the Contractor justifies to the Department a need for additional information and how the extension is in the enrollee's interest.

b. Expedited Authorization Decisions

i. For cases in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three (3) working days after receipt of the request for service.

ii. The Contractor may extend the three (3) working days turnaround time frame by up to fourteen (14) calendar days if the enrollee requests an extension or the Contractor justifies to the Department a need for additional information and how the extension is in the enrollee's interest.

If the Contractor delegates (subcontracts) responsibilities for UM with a subcontractor, the Contract must have a mechanism in place to ensure that these standards are met by the subcontractor. The Contractor must ensure that the preauthorization requirements do not apply to emergency care, family planning services, preventive services, and basic prenatal care. The UM plan shall be submitted annually and upon revision.

The Contractor (the enrollee's current MCO) shall assume responsibility for all managed care contract covered services authorized by either the Department or a previous MCO, which are rendered after the enrollment effective date, in accordance with provisions described in Article II.G.37 of this Contract.

5. Credentialing/Recredentialing Policies and Procedures

The Contractor's QIP shall contain the proper provisions to determine whether physicians and other health care professionals who are licensed by the Commonwealth and who are under contract with the Contractor or it's subcontractor(s) and are qualified to perform their medical or clinical services. The Contractor shall have written policies and procedures for the credentialing process that matches the credentialing and recredentialing standards of the most recent guidelines from NCQA and in accordance with 12VAC5-408-170 of the Virginia Administrative Code. The Contractor's recredentialing process shall include the consideration of performance indicators obtained through the QIP, utilization management program, grievance and appeals system, and enrollee satisfaction surveys. The Contractor shall perform an annual review on all subcontractors to assure that the health care professionals under contract with the

subcontractor are qualified to perform the services under this contract. The Contractor must have in place a mechanism for reporting to the appropriate authorities any actions that seriously impact quality of care, and which may result in suspension or termination of a practitioner's license. The Contractor shall report quarterly those providers who have failed to meet accreditation/credentialing standards.

6. Practice Guidelines

The Contractor shall establish practice guidelines as described in this section, and that are congruent with current NCQA Standards.

a. Adoption of Practice Guidelines

The Contractor shall adopt practice guidelines that meet the following requirements:

i. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

ii. Consider the needs of the enrollees;

iii. Are adopted in consultation with contracting health care professionals; and

iv. Are reviewed and updated periodically as appropriate.

b. Dissemination of Guidelines

The Contractor shall disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees. Additionally, the Contractor shall provide a copy to the Department on an annual basis.

c. Application of Guidelines

Contractor decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the established guidelines.

8. Monitoring and Evaluation of Enrollee Grievances

The Contractor shall have in place a mechanism to link its enrollee complaints, grievances and appeals system, as set forth in Article II, to the QIP and credentialing process.

The Contractor shall, at a minimum, track trends in complaints, appeals and grievances and incorporate this information into the QI process. The Contractor's complaints and grievances system shall be consistent with Federal and State regulations and the most current NCQA standards.

9. Department Oversight

The Department reserves the right to review the Contractor's policies and procedures and determine conditions for formal notification to the Department of situations involving quality of care.

10. Disease Management Programs

The Contractor must have, at a minimum, disease management programs that focus on improving the health status of FAMIS enrollees diagnosed with asthma, coronary artery disease (CAD), congestive heart failure (CHF), COPD, and/or diabetes. A special focus shall be placed on pediatric asthma and pediatric diabetes programs Nothing in this section shall limit the Contractor from implementing additional disease management programs.

In addition, no later than July 1, 2007 the Contractor shall develop and implement a defined disease management program that focuses on improving the health status of children identified as obese.

The Contractor must supply to DMAS prior to implementation a description of each disease management program, which outlines specific goals and benchmarks, and samples of materials to be sent to enrollees.

Program results must be reported annually to the Department and include prior year's outcomes, including results of HEDIS (as listed under Section K of this contract), and other performance measures, the Contractor shall provide to DMAS separate reports for the following:

a. Children with asthma
b. Children with diabetes

The Contractor must have operational disease state management programs, as set forth in this contract, in order for the Contractor to serve eligible populations. The Contractor must have a process in place to refer enrollees with kidney disease to the National Kidney Foundation.

L. MEDICAL RECORDS

The Contractor shall have a requirement of all network providers that medical records will be maintained in paper or electronic form for all enrolled enrollees. The Contractor shall require compliance of all providers and subcontractors with the security and confidentiality of records standards, as detailed in Article IX of this contract. Each report must contain the valid recipient Medicaid/FAMIS Plus identification number. If the ID number is not valid, the report will be returned to the Contractor for correction. Additionally, the Contractor shall maintain standards for medical records that are congruent with NCQA guidelines. The requirements shall:

a. Include written policies to ensure that medical records are safeguarded against loss, destruction, or unauthorized use. The Contractor shall have written procedures for release of information and obtaining consent for treatment.

b. Include procedures maintained by the Contractor or maintained by network provider(s) so that individual medical records for each enrollee are made readily available to the Department and to appropriate health professionals. Procedures shall also exist to provide for prompt transfer of records to other in- or out-of-network providers for the medical management of the enrollee. The Contractor shall use its best efforts to assist enrollees and their authorized representatives in obtaining records within ten (10) business days of the record request. The Contractor will identify an individual who can assist enrollees and their authorized representatives in obtaining records. The Contractor shall use its best efforts, when an enrollee changes PCPs, to assure that his or her medical records or copies of medical records are made available to the new PCP within ten (10) business days from receipt of request from the enrollee.

c. Include procedures to assure that medical records are readily available for the Department, its contracted quality assurance oversight provider, Contractor-wide quality assurance and utilization review activities and provide adequate medical and other clinical data required for quality improvement, utilization management, encounter data validation, and payment activities. Specifically, the Contractor shall use its best efforts to ensure that all medical records are provided within the greater of the amount of time, if specified in the request or twenty (20) business days. The Department shall be afforded access within twenty (20) calendar days to all enrollees' medical records, whether electronic or paper. Access shall be afforded within ten (10) calendar days upon request for a single record or a small volume of records. The Contractor may be given only a partial list of records required for on-site audits with no advance list of records to be reviewed or one (1) week's notice, with the remaining list of records presented at the time of audit.

d. Provide for adequate information and record transfer procedures to provide continuity of care when enrollees are treated by more than one provider.

M. MANAGEMENT INFORMATION SYSTEMS

HIPAA Compliance

The Contractor shall comply with all Federal Regulations with regards to handling, processing, or using Health Care Data. This includes but is not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. These regulations are evolving and are therefore of a dynamic nature. The Contractor must keep abreast of the regulations and be able to reach full compliance. Since this is a federal law and regulations that apply to all health care information, the Contractor must comply with the HIPAA regulations at no additional cost to DMAS. The only exception to the previous is that DMAS will continue to issue the certificates of creditable coverage.

The Contractor must have in place management information systems capable of furnishing the Department with timely, accurate, and complete information about the FAMIS program. Such information systems shall

a. Accept and process enrollment transmissions and reconciling them with the MCO enrollment/eligibility file;

b. Accept and process provider claims and encounter data as set forth in this Contract;

c. Track provider network composition and access, and grievances and appeals as set forth in this Contract;

d. Perform quality improvement activities, as set forth in this Contract;

e. Furnish the Department with timely, accurate and complete clinical and administrative information, as set forth in this Contract;

f. Stop co-payments;

g. Provide utilization reports; and

h. Accept capitation transmissions.

i. Ensure that data received from provides is accurate and complete by:

   i. Verifying the accuracy and timeliness of reported data;

   ii. Screening the data for completeness, logic, and consistency; and
   iii. Collecting service information in standardized formats as set forth in this Contract

j. In accordance with the requirements set forth in 1932(d)(4) and 1173(b)(2) of the Social Security Act, the Contractor must assign unique identifiers to providers, including physicians, and must require that providers use these identifiers when submitting data to the Contractor.

k. Any reference to "systems" in this article shall mean the Contractor's MIS unless otherwise specified. If the Contractor subcontracts any MIS functions, then these requirements apply to the subcontractor's systems. For example, if the Contractor contracts with a mental health network to provide services and pay claims/collect encounters, then these requirements shall apply to the mental health network's systems. However, if the Contractor contracts with a mental health network only to provide mental health services, then these requirements do not apply.

l. The Contractor shall accommodate and modify future system changes/enhancements to claims processing or other, related systems as soon as possible after being notified by the State of the change or enhancement. The Contractor shall advise the Department in writing of the anticipated implementation date of the system changes/enhancements. In addition, the system shall be able to accommodate all future requirements based upon Federal and State statutes, policies and regulations. Unless otherwise agreed by the State, the Contractor shall be responsible for the cost of these changes.

The Contractor shall make available to the Department and CMS, upon request, all data collected by the Contractor in relation to and in support of the program.

N. ELECTRONIC DATA SUBMISSION INCLUDING ENCOUNTER CLAIMS

The Contractor may not transmit PHI over the Internet or any other insecure or open communication channel unless such information is encrypted or otherwise safeguarded using procedures no less stringent that those described in 45 CFR § 142.308(d).

If the Contractor stores or maintains PHI in encrypted form, the Contractor shall, promptly at the Department's request, provide the Department with the software keys or keys to unlock such information.

1. Electronic Data Interchange (EDI)

Each party will transmit documents directly or through a third party value added network. Either party may select, or modify a selection of a Value-Added Network (VAN) with up to thirty (30) days written notice.

Each party will be solely responsible for the costs of any VAN with which it contracts. Each party will be liable to the other for the acts or omissions of its VAN while transmitting, receiving, storing or handling documents. Each party is solely responsible

for complying with the subscription terms and conditions of the VAN he or she selects, and for any and all financial liabilities resulting from that subscription agreement.

2. Test Data Transmission

Each party agrees to actively send and receive test data transmissions until approved. Supplier agrees to receive redundant transmission (e.g. faxed copy and electronic), if required by the Department, for up to thirty (30) days after a successful EDI link is established.

3. Garbled Transmissions

If a party receives an unintelligible document, that party will promptly notify the sending party (if identifiable from the received document). If the sending party is identifiable from the document but the receiving party failed to give notice that the document is unintelligible, the records of the sending party will govern. If the sending party is not identifiable from the document, the records of the party receiving the unintelligible document will govern.

~~4.~~ Certification

Any payment information from the Contractor that is used for rate setting purposes (e.g. any encounter data) or any payment related data required by the state must be certified with the signature of the Contractor's Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer of the Contractor.

The Contractor must use Attachment XVIII, Certification of Encounter Data, on a monthly basis reflecting prior submissions of encounters; and, Attachment XXIV, Certification of Data, for certification of non-encounter payment related data submissions within one (1) week of the date of submission.

The use of this form will ensure that the amount paid to providers by the Contractor shall not be subject to Freedom of Information Act (FOIA) requests. The Department can deny FOIA requests for such protected information pursuant to § 2.2 4342 (F) of the Procurement Procurement Act.

5. Enforceability and Admissibility

Any document properly transmitted pursuant to this Agreement will be deemed for all purposes (1) to be a "writing" or "in writing," and (2) to constitute an "original" when printed from electronic records established and maintained in the ordinary course of business. Any document which is transmitted pursuant to the EDI terms of this Agreement will be as legally sufficient as a written, signed, paper document exchanged

between the parties, notwithstanding any legal requirement that the document be in writing or signed. Documents introduced as evidence in any judicial, arbitration, mediation or administrative proceeding will be admissible to the same extent as business records maintained in written form.

6. Timeliness, Accuracy and Completeness of Data

The Contractor must ensure that all electronic data submitted to the Department are timely, accurate and complete. At a minimum, encounter data and provider rosters will be submitted via electronic media.

In the event that electronic provider data are returned to the Contractor due to errors, the Contractor agrees to process incorrect data and resubmit within five (5) business days. All other electronic data returned for errors must be corrected and resubmitted within thirty (30) days. The Contractor agrees to correct encounter claims, where appropriate, and resubmit corrected encounter claims in accordance with the specifications set forth in this subsection.

The Contractor must evaluate the completeness of data from their providers on a periodic basis, in particular providers who are capitated or paid under a global fee arrangement. The Contractor must report annually the plan used by the Contractor, including frequency of review, to ensure encounter data completeness. Any deficiencies found through the review process must be reported to the Department within 60 calendar days. A corrective action plan to any deficiencies found must be provided to the Department within 30 calendar days after notification of any deficiencies.

7. Encounter Claims Data Submission

All encounters shall be submitted using the nationally recognized formats defined below:

- Hospital, Professional, and Dental Claims – submit using the American National Standards Institute (ANSI) 837, version 40.10 with addenda, and
- Pharmacy Claims – submit using the National Council for Prescription Drug Programs (NCPDP) Batch Version 1.1.

All encounters must be submitted to the Virginia Medicaid Management Information System (VAMMIS) Gateway System to interface with the First Health File Transfer Protocol (FTP) Server.

Submissions must be made at least monthly and may be made more frequently with the approval of the Department. Files with HIPAA defined level 1 or level 2 errors in the ISA, GS, GE, or ISE records will be rejected and a negative 997 sent back to the submitter. The entire file must be resubmitted after the problem is fixed. Files with HIPAA defined level 1 or level 2 errors inside a ST-SE loop will have that ST-SE loop rejected and a negative 997 will be sent back to the submitter identifying the loop. Any other ST-SE loops, which do not have level 1 or level 2 errors, will be processed. Only the rejected ST-SE loops should be resubmitted after fixing the problem. Errors on

rejected files or ST-SE loops must be corrected and resubmitted within thirty (30) days of the date.

For the purposes of this Contract, an encounter is any service received by the enrollee and processed by the Contractor and its subcontractors. The Contractor shall submit encounters/claims for all services it covers, including, but not limited to, inpatient and outpatient procedures ,including psychiatric procedures, well child care, pharmacy, durable medical equipment (DME), and home health care services. The Contractor is responsible for submission of data from all of its subcontractors to the State or its agent in the specified format that meets all specifications required by the Department and matches the requirements placed on the Contractor by the Department for encounters. This data shall be submitted and on a timely basis.

Except for encounters involving appeals, the Contractor shall submit to the Department ALL electronic encounter claims within sixty (60) calendar days of receipt or within sixty (60) calendar days of inpatient discharge. Late data will be accepted but the Department reserves the right to set and adjust timeliness standards as required in order to comply with State and Federal reporting requirements. The Contractor is strongly encouraged to submit encounter data as received and discouraged from waiting the full time allotted before submitting the encounter data to the Department. The Department reserves the right to require written explanations of all appeals.

The Contractor shall be required to pass a testing phase for each of the encounter claim types identified by the Department before production encounter data will be accepted. The Contractor shall pass the testing phase for all encounter claim type submissions within twelve calendar weeks from the effective date of the change.

The Contractor shall submit the test encounter data to the Department's fiscal agent electronically according to the specifications of the HIPAA Implementation and Companion Guidelines.

The Contractor shall be responsible for passing a phased-in test process prior to submitting production encounter data. The Contractor shall utilize production encounter data, systems, tables, and programs when processing encounter test files.

8. Encounter Data Reconciliation

The Contractor shall fully cooperate with all DMAS efforts to monitor the Contractor's compliance with the requirements of encounter data submission, including encounter data accuracy, completeness, and timeliness of submission to the DMAS Fiscal Agent. The Contractor shall comply with all requests related to encounter monitoring data in a timely manner.

9. Administrative Provider Identification Numbers

The Contractor is responsible to ensure that all encounter claims are identified with an active Virginia Medicaid ID number, or NPI/API atypical ID number, or an active Administrative Provider Identification number. Monthly, DMAS produces a provider file that includes all active and terminated Virginia Medicaid Providers. The Contractor is responsible for maintaining the correct provider Medicaid ID for the claim and service date. The Contractor will make best effort that as part of its credentialing process all providers, including ancillary providers, (i.e. vision, pharmacy, etc.), apply for enrollment in the Medicaid program.

Upon receipt of the DMAS provider file, the Contractor will add, update, edit, etc. the Virginia Medicaid ID numbers or NPI/APIatypical ID number, by effective date, as appropriate. Monthly, or in the event that in a given month no Administrative Provider Ids are required, then as needed, the Contractor will submit a file for any provider claim(s) that an active Virginia Medicaid ID or NPI/APIatypical ID number is not available. The file layout is defined below:

a. NPIProvider Last Name (maximum 17 characters)
b. Provider TypeFirst Name (maximum 10 characters)
c. LastBusiness Name (maximum 38 characters)
d. First Name Eligibility Date (MM/ DD/CCYY format
e. Middle InitialProvider Type (Maximum 20 characters)
f. SuffixLicense Number (Maximum 10 characters)
g. TitleProvider Specialty 1 (Maximum 20 characters)
h. AddressProvider Specialty 2 (Maximum 20 characters)
i. CityProvider Specialty 3 (Maximum 20 characters)
j. StateProvider Specialty 4 (Maximum 20 characters)
k. ZipSocial Security Number (59 characters)
l. + 4FEIN (9 characters)
m. Contact Name IRS Name (Maximum 39 characters)
n. Phone (including area code)Provider Address (servicing location, not a billing location) (Maximum 40 characters)
o. Provider Begin DateCity (Maximum 16 characters)
p. License NumberState (2 characters)
q. State of License Zip (Maximum 5 characters)
r. License Begin Date
s. License End Date
t. Specialty
u. Languages

This should be submitted monthly via e-mail, CD or diskette to the attention of the Encounter Contract Analyst. As of the effective date of mandatory compliance with the CMS NPI Rule, no encounter record will be accepted unless the provider has an active record (NPI/API) in the VA MMIS system. At a date to be determined, encounter files will not be accepted, unless all providers have active Virginia Medicaid ID number or APIN.

O. REPORTING REQUIREMENTS

The Contractor shall establish and maintain all necessary systems, policies and procedures to fulfill the reporting requirements in Attachment VI to this Contract. The encounter data aspects of these requirements shall conform to the nationally recognized standard (ANSI or NCPDP) currently in use by DMAS . The Department reserves the right to change/modify these requirements, as is necessary to meet State and Federal (including HIPAA) reporting requirements.

The Contractor shall submit an organizational chart annually that outlines the FAMIS operating division within its plan. The organizational chart should include all operations that handle FAMIS (claims, member services, outreach/marketing, health services, etc.).

The contractor shall submit annually an updated company background that includes any awards, major changes or sanctions imposed since the last annual report. The Contractor shall also submit the same information for all of its subcontractors.

The MCO shall forward via facsimile monthly reports to the Department or its designated agent that include, at a minimum, enrollee address changes, third party liability (TPL) information, newborns, eligibility evaluations, out of pocket maximum payments, and other reports that may impact enrollees' FAMIS eligibility. The MCO shall forward via facsimile to the Department or its designated agent reports regarding death of an enrollee (sentinel events). The report shall be faxed immediately upon evidence of the information.

If an enrollee moves from one locality to another locality and is required to enroll with a different MCO as a result of the move, the current MCO must provide information to the Department or it designated agent indicating the year to date co-payment amount, and shall be responsible for communicating information about services that have received prior authorization. This information shall be forwarded to the enrollee's new MCO. DMAS and the MCOs shall agree upon the frequency and transmission method of such reports.

DMAS shall be responsible for ensuring that participating MCOs provide to the Department or its designated agent all source data required to produce these reports.

The Department shall determine all reporting formats. Monthly reports shall include monthly year-to-date summaries by calendar year and by State fiscal year. Quarterly reports shall include quarterly year-to-date summaries by calendar year and by State fiscal year.

The MCO shall provide annually the following FAMIS MOMS reports which include frequency of ongoing prenatal care, discharge and average length of stay (maternity

care), c-section rate, vaginal birth after c-section (VBAC) occurrence, , and postpartum care rates

P. ENROLLEE NOTICES, INQUIRIES, COMPLAINTS, GRIEVANCES, AND APPEAL PROCEDURES

The Contractor shall provide a timely response to all inquiries or claims received from enrollees or on behalf of enrollees. In any instance where the enrollee submits a claim for services directly to the Contractor, the Contractor's response to the enrollee must be timely, in writing, and issued at the time of any action affecting the claim. This response to the enrollee is required regardless of any response that the Contractor sends to the provider of service. The response shall inform the enrollee regarding approval or denial of coverage and shall detail any further action that is required in order to process the claim. If the claim is denied, the Contractor must adhere to the appeal requirements outlined in this contract.

The Contractor shall, whenever an enrollee's (who is enrolled on the date of service) request for covered services is reduced, delayed, denied, terminated, or payment for services is denied (where the enrollee is liable/potentially liable for the cost of services), provide a written notice in accordance with the notice provisions in the Department's enrollee appeals regulations 12VAC30-141-40 through 12VAC30-141-70 and 42 Code of Federal Regulations 457.1130 through 42 CFR 457.1180. The Contractor has the option to send the enrollee notice an explanation of benefits or a notice of adverse action. Any notice must include the requirements set forth in this contract. The Department or its designated agent shall handle appeals regarding program eligibility.

The notice to the enrollee shall include, at a minimum, all of the contents listed in 42 CFR § 457.1180. In addition, it shall inform the enrollee about his or her opportunity to file a grievance or an appeal with the Contractor, include the phone number and name of the contact person at the Contractor's office.

The Contractor shall comply with the Department's hearing process, no more nor less and in the same manner as is required for all other FAMIS evidentiary hearings.

1. Contractor Policies and Procedures for Complaints, Grievances, and Appeals

a. The Contractor shall have written policies and procedures, which describe the informal and formal grievance and appeals process and how it operates, and the process must be in compliance with 12VAC30-141-40 through 12VAC30-141-70 and 42 CFR § 457.1130 through 42 CFR 457.1180 as amended. These written directives shall describe how the Contractor intends to receive, track, review, and report all enrollee complaints. The procedures and any changes to the procedures must be reviewed and approved in writing by the Department prior to implementation. The Contractor shall provide grievance or complaint and

appeals forms and/or written procedures to enrollees who wish to register written grievances or appeals. The procedures must provide for prompt resolution of the issue and involve the participation of individuals with the authority to require corrective action. Specific requirements regarding enrollee notices, complaints, grievances, and appeals are contained in this Article.

b. The complaint, grievance, and appeals processes must be integrated with the QIP. The complaint, grievance and appeals process shall include the following:

i. Procedures for registering and responding to complaints, grievances and appeals in a timely fashion;

ii. Documentation of the substance of the complaint or grievance or appeal and the actions taken;

iii. Procedures to ensure the resolution of the complaint;

iv. Aggregation and analysis of these data and use of the data for quality improvement.

c. The Contractor shall issue grievance and appeal decisions within fourteen (14) days from the date of initial receipt of the grievance and after all information has been received in accordance with 12VAC30-141-60. The decision must be in writing and shall include but not be limited to:

i. The decision reached by the Contractor,

ii. The reasons for the decision,

iii. The policies or procedures which provide the basis for the decision, and

iv. A clear explanation of further appeal rights and the time frame for filing an appeal.

d. The Contractor shall provide the Department with a copy of its final decision of the grievance and appeals process within forty-eight (48) hours of receipt of the complaint in cases of medical emergencies in which delay could result in death of or serious harm to an enrollee. Written confirmation to the enrollee of the decision shall promptly follow the verbal notice of the expedited decision.

e. The Contractor must maintain a record keeping and tracking system for complaints, grievances and appeals that includes a copy of the original

written complaint, grievance, or appeal, the decision, and the nature of the decision. This system shall distinguish FAMIS from commercial enrollees, if the Contractor does not have a separate system for FAMIS enrollees.

2. Enrollee Appeals to the External Review Organization

Any formal grievance decision by the Contractor may be appealed by the enrollee for an external review in accordance with the Review of Adverse Actions regulations at 12VAC30-141-40 *et seq*. The Contractor shall comply with the external review decision. The External Review Organization's decision in these matters shall be final and shall not be subject to appeal by the Contractor. FAMIS enrollees must exhaust the MCOs internal appeals process before initiating external review.

The Contractor shall notify the enrollee in writing once a final adverse decision has been rendered that the enrollee may submit a written request to the Department for an external review of the adverse action. The Contractor's communication to the enrollee should include clarification that the review will be completed by an independent external review organization. The Contractor will provide the name and contact information of the external review organization.

The Contractor shall provide to the External Review Organization all information necessary for any enrollee appeal within a time frame established by the Department.

If an enrollee wishes to file an appeal with the External Review Organization the appeal must be filed within thirty (30) calendar days of the enrollee's receipt of notice of the final decision from the MCO.

3. Contractor Inquiry, Complaint, Grievance and Appeals Reporting

The Contractor shall submit to the Department by the fifteenth (15^{th}) day of the month after the end of each month a mutually agreed upon summary report of all provider and recipient inquires, complaints, grievances, and appeals as illustrated in Attachment V.

The Contractor shall also submit to the Department by the fifteenth (15) day of the month after the end of each month a log of complaints, grievances and appeals filed by enrollees under this Contract. The FAMIS report must be a document separate and apart from the Medallion II report.

a. Complaint, grievance and appeal categories identified shall be organized or grouped by the following general guidelines:

   i. Access to Health Services

   ii. Utilization and Medical Management Decisions

iii. Provider Care and Treatment

iv. Payment and Reimbursement Issues

v. Administrative Issues

b. The log shall contain the following information for each complaint, grievance or appeal:

i. The date of the communication;

ii. The enrollee's FAMIS identification number;

iii. Whether the complaint, grievance, or appeal was written or oral;

iv. Indication of whether the dissatisfaction was a complaint, grievance, or an appeal;

v. The category, specified in subsection a, of each complaint or inquiry;

vi. A description subcategories or specific reason codes for each complaint, grievance, and appeal. Attachment XII contains illustrative examples of subcategories or specific reason codes.

vii. The inquiry/complaint resolution; and

viii. The resolution date.

The Contractor may use reports from its existing Member Services system if the system meets the above-stated Department criteria. The Department reserves the right to request submission of the log in an electronic format in the future. The Department reserves the right to modify the requirements for complaint and grievance reporting based on the final requirements of Chapter 891 of the 1998 Virginia Acts of the Virginia General Assembly.

The Contractor shall obtain written approval from the Department prior to implementing any changes to its enrollee complaint, grievance and appeals procedures. The Contractor shall make any changes to its enrollee grievance procedures that are required by the Department.

Q. DATA CERTIFICATIONS AND PROGRAM INTEGRITY REQUIREMENTS

1. Data Certifications

a. Data Requiring Certification

i. Any payment information from the contractor that is used for rate setting purposes, any encounter data, or any payment related data required by the state must be certified by the contractor's Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer of the contractor. The certifications shall attest that the contractor has reviewed the encounter data or other information and attests, based on best knowledge, information, and belief as of the date signed and submitted that it is accurate, complete and truthful. The contractor must use Attachment XVIII, Certification of Encounter Data, on a monthly basis reflecting prior submissions of encounters; and, Attachment XVIII, Certification of Data, for certification of non-encounter payment related data submissions within one (1) week of the date of submission.

b. Source, Content, and Timing of Certification

i. Source of Certification – Data as specified in this section must be certified by one of the following individuals: the Contractor's Chief Executive Officer (CEO); Chief Financial Officer (CFO), or other individual with delegated authority to sign for and reports directly to the Contractor's CEO or CFO.

ii. Content of Certification – The certification must attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of the data submitted.

iii. Timing of Certification – The Contractor must submit the certification concurrently with each submission.

2. Medicaid Program Integrity Requirements

The Contractor must have in place policies and procedures for ensuring protections against actual or potential fraud and abuse. The Contractor must have a comprehensive Virginia *Medicaid* Program Integrity Plan to detect, correct and prevent fraud, waste, and abuse. The Virginia *Medicaid* Program Integrity Plan must define how the Contractor will adequately identify and report suspected fraud and abuse by enrollees, by network providers, by subcontractors and by the Contractor. The Virginia *Medicaid* Program Integrity Plan must be submitted annually. The Plan will include a plan with set goals and objectives and describe the processes involved including data mining, software, audit findings for the Virginia Medicaid All fraudulent activities or other program abuses shall be subject to the laws and regulations of the Commonwealth of Virginia and/or Federal laws and regulations.

The Contractor shall develop a written integrity plan specific to its Virginia Medicaid program. The Contractor will have in place a process for assessment of all claims for

fraudulent activity by enrollees and providers through utilization of computer software or through periodic audits of medical records.

The Contractor shall submit electronically to the Department each quarter any findings of fraud and abuse. The report will include the following:

- Number of cases by providers and recipients investigated with resolution
- Cases referred to the Department for action must include:
  - Provider/Recipient name
  - Date case was opened
  - Reason(s) for initiating case
  - Date case was cleared (if applicable)
  - Findings/Corrective action taken
  - Overpayment amount
  - Recovery action taken/completed

The Contractor will provide the Department on October 1st each year an annual summary of activities and results.

The Department shall share fraudulent provider activity with the Contractor through an electronic database that shall be updated at least monthly.

The Contractor shall refer recipients and providers, who have notified the Contractor of suspected fraud or abuse, to the Department.

The Contractor shall establish written policies for all employees of the Contractor, any Contractor or agent of the Contractor, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31. The written policies shall include detailed provisions regarding the Contractor's policies for detecting and preventing fraud, waste, and abuse. Any Contractor employee handbook shall provide a specific discussion of the Virginia Fraud Against Taxpayers Act, the rights of employees to be protected as whistleblowers, and the Contractor's policies and procedures for detecting and preventing fraud, waste and abuse in accordance with Virginia Fraud Against Taxpayers Act, Va. Code § 8.01-216.1 through 8.01-216.19.

The Contractor's Program Integrity Plan must address the following requirements:

a. Written Policies and Procedures

The Contractor shall have in place written policies and procedures and standards of conduct that articulates the Contractor's commitment to comply with all applicable Federal and State Standards, for the prevention, detection and reporting of incidents of suspected fraud and abuse by enrollees, by network providers, by subcontractors and by the Contractor. The Contractor's program integrity plan must include a method to verify whether services reimbursed were actually furnished to the member.

The contractor should have, at a minimum, the following policies and procedures in place:

- A commitment to comply with applicable statutory, regulatory and contractual commitments.
- A process to respond to potential violations of Federal and State criminal, civil, administrative laws, rules and regulations in a timely basis (no later than 30 days after the determination that there is a potential violation of civil, criminal or administrative law may have occurred).
- Procedures for the identification of potential fraud, waste and abuse in a Contractor's network.
- A process to ensure the Contractor, agents and brokers are marketing in accordance with applicable federal and state laws, including state licensing laws, and CMS policy.
- A process to identify overpayments at any level within the Contractor's network and properly recover such overpayments in accordance with federal and state policy.
- Procedures for corrective actions designed to correct any underlying problems that result in program violations and prevent future misconduct.
- Procedures to retain all records documenting any and all corrective actions imposed and follow-up compliance reviews for future health oversight purposes and/or referral to law enforcement, if necessary.

b. Compliance Officer

The Contractor shall designate a compliance officer and a compliance committee accountable to senior management to coordinate with the Department on any fraud or abuse case. The Contractor may identify different contact people for enrollee fraud and abuse, network provider fraud and abuse, subcontractor fraud and abuse, and Contractor fraud and abuse.

c. Training and Education

The Contractor shall establish effective program integrity training and education for Compliance Officer, all Contractor staff and subcontractors.

d. Effective Lines of Communication Between Contractor Staff

The Contractor shall establish effective lines of communication between the compliance officer, other Contractor staff, enrollees, subcontractors and other Contractor staff. Contractors shall have a system in place to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance from employees and

subcontractors, while maintaining confidentiality. The Contractor shall also establish effective lines of communication with its enrollees.
Contractors shall establish a process to document and track reported concerns and issues, including the status of related investigations and corrective action.

e. Enforcement of Standards Through Well-Publicized Disciplinary Guidelines

The Contractor shall enforce program integrity standards through well-publicized disciplinary guidelines

f. Internal Monitoring and Audit

The contractor shall establish and implement provisions for internal monitoring and auditing.

Procedures for internal monitoring and auditing shall attest and confirm compliance with Medicaid regulations, contractual agreements, and all applicable state and federal laws, as well as internal policies and procedures to protect against potential fraud, waste or abuse.

Contractors shall have a system or plan of ongoing monitoring that is coordinated or executed by the Compliance Officer to assess performance in, at a minimum, areas identified as being at risk. The plan shall include information regarding all the components and activities needed to perform monitoring and auditing, such as Audit Schedule and Methodology, and Types of Auditing.

The plan shall include a schedule that includes a list of all the monitoring and auditing activities for the calendar year. Contractors shall consider a combination of desk and on-site audits, including unannounced internal audits or "spot checks," when developing the schedule.

Contractors shall produce a standard audit report that includes, at a minimum:
• Purpose
• Methodology
• Findings
• Recommendations

In developing the types of audits to include in the plan Contractors shall:
- Determine which risk areas will most likely affect their organization and prioritize the monitoring and audit strategy accordingly.
- Utilize statistical methods in:
    - Randomly selecting facilities, pharmacies, providers, claims, and other areas for review;
    - Determining appropriate sample size; and
    - Extrapolating audit findings to the full universe.

- Assess compliance with internal processes and procedures.
- Review areas previously found non-compliant to determine if the corrective actions taken have fully addressed the underlying problem.

Contractors shall also include in their plan a process for responding to all monitoring and audit results. Corrective action and follow-up shall be led by the Compliance Officer and include actions such as the repayment of identified overpayments and making reports.

The Compliance Officer should maintain a records system to track all compliance actions taken and outcomes of any follow-up reviews to evaluate the success of implementation efforts that may be provided, if necessary, to CMS or to law enforcement, and provide updates on the monitoring and auditing results and corrective action to the Compliance Committee on at least a quarterly basis.

Contractors shall develop as part of their work plan a strategy to monitor and audit subcontractors involved in the delivery of the benefits. Specific data should be analyzed from subcontractors, as applicable and appropriate, and reviewed regularly as routine reports are collected and monitored.

Contractors shall include routine and random auditing as part of their contractual agreement with subcontractors. Contractors shall include in their work plan the number of subcontractors that will be audited each year, how the subcontractors will be identified for auditing, and should make it a priority to conduct a certain number of on-site audits.

Contractors are encouraged to invest in data analysis software applications that give them the ability to analyze large amounts of data. Data analysis should include the comparison of claim information against other data (e.g., provider, drug provided, diagnoses, or beneficiaries) to identify potential errors and/or potential fraud.

g. Process for Reporting Suspected or Actual Fraud and Abuse

The Contractor shall provide information and a procedure for enrollees, network providers and subcontractors to report incidents of suspected or actual fraud and abuse to the Contractor and to the Commonwealth.

h. Prompt Response to Reported Offenses

The Contractor shall report all potential or actual fraud and abuse to the Department. The Contractor shall have procedures for ensuring prompt responses to detected offenses and development of corrective action initiatives.

i. Development of Corrective Action Initiatives

The Contractor's program integrity plan shall include provisions for corrective action initiatives. The Contractors shall conduct appropriate corrective actions (for example, repayment of overpayments and disciplinary actions against responsible individuals) in response to potential violations. A corrective action plan should be tailored to address the particular misconduct identified. The corrective action plan should provide structure with timeframes so as not to allow continued misconduct.

j. Time Frame for Reporting Fraud and Abuse to the Department

The Contractor shall report incidents of suspected or actual fraud and abuse to the Department within forty-eight (48) hours of initiation of any investigative action by the Contractor or within forty-eight (48) hours of Contractor notification that another entity is conducting such an investigation of the Contractor, its network providers, or its enrollees.

k. Cooperation with State and Federal Investigations

The Contractor shall cooperate with all fraud and abuse investigation efforts by the Department and other State and Federal offices.

R. ACCESS TO AND RETENTION OF RECORDS

In addition to the requirements outlined below, the Contractor must comply, and must require compliance by its subcontractors and providers, with HIPAA security and confidentiality of records standards, detailed in Article IX of this Contract.

1. Access to Records

The Department and its duly authorized representatives shall have access to any books, fee schedules, documents, papers, and records of the Contractor and any of its subcontractors or network providers.

The Contractor shall make an individual's PHI available to the Department within thirty (30) days of an individual's request for such information as notified by the Department.

The Contractor shall make PHI available for amendment correction and shall incorporate any amendments or corrections to PHI within thirty (30) days of notification by the Department.

The Department, or its duly authorized representatives, shall be allowed to inspect, copy, and audit any medical and/or financial records of the Contractor, its subcontractors and its network providers.

2. Retention of Records

All records and reports relating to this Contract shall be retained by the Contractor for a period of six (6) years after final payment is made under this Contract or in the event that this Contract is renewed six (6) years after the renewal date. When an audit, litigation, or other action involving records is initiated prior to the end of said period, however, records shall be maintained for a period of six (6) years following resolution of such action. Copies on microfilm or other appropriate media of the documents contemplated herein may be substituted for the originals provided that the microfilming or other duplicating procedures are reliable and are supported by an effective retrieval system which meets legal requirements to support litigation, and to be admissible into evidence in any court of law.

S. ACCESS TO PREMISES

The Contractor shall allow duly authorized agents or representatives of the State or Federal Government, during normal business hours, access to Contractor's premises, subcontractor's premises, or the premises of the Contractor's network providers to inspect, audit, monitor or otherwise evaluate the performance of the Contractor's, subcontractor's or network provider's contractual activities and shall forthwith produce all records requested as part of such review or audit. In the event right of access is requested under this section, the Contractor, subcontractor, or network provider shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal personnel conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Contractor's or subcontractor's activities. The Contractor will be given thirty (30) calendar days to respond to any preliminary findings of an audit before the Department shall finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

The Department, the Office of the Attorney General of the Commonwealth of Virginia, the Federal Department of Health and Human Services, and/or their duly authorized representatives shall be allowed access to evaluate through inspection or other means, the quality, appropriateness, and timeliness of services performed under this Contract.

T. ANNUAL AUDIT BY INDEPENDENT AUDITOR

The Contractor shall provide the Department with a copy of its annual audit report required by the Bureau of Insurance, at the time it is submitted to the Bureau of Insurance. The Department reserves the right to require the Contractor to engage the services of an outside independent auditor to conduct a general audit of the Contractor's major managed care functions performed on behalf of the Commonwealth. The Contractor shall provide the Department a copy of such an audit within thirty (30) calendar days of completion of the audit.

U. CONFLICT OF INTEREST

Nothing in this Contract shall be construed to prevent the Contractor from engaging in activities unrelated to this Contract, including the provision of health services to persons other than those covered under this Contract, provided, however, that the Contractor furnishes the Department with full prior disclosure of such other activities, including the provision of health services that would reasonable be expected to detrimentally impact FAMIS.

V. NON-DISCRIMINATION

The Contractor shall comply with all applicable Federal and State laws relating to non-discrimination and equal employment opportunity and assure physical and program accessibility of all services to persons with physical and sensory disabilities pursuant to § 504 of the Federal Rehabilitation Act of 1973, as amended (29 U.S.C. 794), and with all requirements imposed by applicable regulations in 45 CFR Part 84, Title VI of the Civil Rights Act, the Americans with Disabilities Act, the Age Discrimination and Employment Act of 1967, and the Age Discrimination Act of 1975. In connection with the performance of work under this Contract, the Contractor agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability or national origin. The Contractor shall comply with the provisions of Executive Order 11246, "Equal Employment Opportunity," as amended by Executive Order 11375 and supplemented in the United States Department of Labor regulations (41 CFR 60).

The Contractor agrees to post in conspicuous places, available for employees and applicants for employment, notices to be provided by the Contractor setting forth the provisions of the non-discrimination clause.

W. COMPLIANCE WITH APPLICABLE LAWS AND REGULATIONS

The Contractor shall observe and comply with all Federal [(including the Health Insurance Portability and Accountability Act (HIPAA)] and State laws and regulations in effect when the Contract is signed or which may come into effect during the term of the Contract which in any manner affect the Contractor's performance under this Contract.

In case of contract disputes, these documents will be reviewed and considered in the order shown to resolve said disputes:

a. Federal Regulations (including HIPAA)
b. Virginia State Child Health Plan
c. FAMIS State Regulations
d. FAMIS Contract
e. Departmental Memos and Documents

ARTICLE III - FUNCTIONS AND DUTIES OF THE DEPARTMENT

The Department shall be responsible for the administration of this Contract. Administration of the Contract shall be conducted in good faith within the resources of the State, but in the best interest of the enrollees. The Department shall retain full authority for the administration of the FAMIS Program in accordance with the requirements of Federal and State laws and regulations.

A. DETERMINATION OF FAMIS ELIGIBILITY AND FAMIS ENROLLMENT

The Department, through its designated agents, and local Departments of Social Services, shall have responsibility for determining the eligibility of an individual for FAMIS funded services. The Department shall have sole responsibility for determining enrollment in the Contractor's plan.

B. ASSIGNMENT

The Department or its designated agent will assign enrollees to MCOs as described in Article II.

C. ENROLLMENT REPORTS/INFORMATION EXCHANGE

For the coverage throughout the term of the Contract, the Department or its designated agent shall transmit MCO Enrollment Reports to the Contractor. These reports shall provide the Contractor with ongoing information about its FAMIS enrollees and disenrollees and shall be used as the basis for the capitation payments. The Department or its designated agent shall process and disseminate via compatible electronic mechanism to FAMIS MCOs the enrollment and capitation payment information and reports. The MCO must receive from the Department the enrollment and capitation payment information monthly as well as by transaction type. The MCO Enrollment Reports will be generated in the following sequence:

a. The Mid-month and End-of-the Month Enrollment Report will list all of the Contractor's enrollees for the enrollment month who are known on the report generation date. The Mid-Month Enrollment Report will be provided to the Contractor on the twentieth (20^{th}) day of the month prior to enrollee enrollment. The End of the Month Enrollment Report will be provided to the Contractor on the second (2^{nd}) day of the month following recipient enrollment. The report will be available in electronic format and other formats and will contain at a minimum: enrollee name, FAMIS number, aid category, age, sex, and indication of capitation region or locality. The report will be sorted by enrollment status (new enrollee, continuing enrollee, or disenrollee).

b. The Payment transmission will list all of the Contractor's enrollees for the enrollment month who are known on the report generation date. The Payment Report will be provided to the Contractor prior to client

enrollment. The report will be available in electronic and other formats and will contain at a minimum: enrollee name, FAMIS number, age, sex, an indication of capitation region or locality, and amount of monthly capitation payment for the enrollee. The report will be sorted by enrollment status (new enrollee or continuing enrollee).

The Department will be responsible for the processing, making and reconciling MCO payments. Payment for services rendered shall be provided via check or electronic fund transfer.

The Department shall be able to generate adjustments to past capitation rates based on retroactive adjustments to enrollee or managed care provider information. All such adjustments shall be incorporated into the payment processing adjustment process and remittance advice.

c. All enrollment reports will be provided to MCOs through bulletin board.

d. The Contractor shall work with the Department or its designated agent to ensure that the FAMIS enrollment and payment databases of the Department/agent and the Contractor are reconciled. The Department may audit the Contractor's FAMIS enrollment and payment database.

e. The Department shall be responsible for identifying Native American and Alaska Native enrollees and shall provide the Contractor a list of known Native American and Alaska Native enrollees each month.

f. Retroactive adjustments to enrollment and payment files shall be forwarded to the Contractor as soon as possible upon receipt of updated/corrected information. The Contractor shall cover retroactive adjustments to enrollment without regard to timeliness of the adjustment. The Contractor shall assure correct payment to providers as a result of enrollment update/correction. The Department shall assure correct payment to the Contractor for any retroactive enrollment adjustments.

D. MCO REVIEW OF AUDIT FINDINGS

The Department shall provide the results of any audit findings to the Contractor for review. The Department may seek clarification of the results of any audit findings from the Contractor or its duly authorized representative for the purpose of facilitating the Contractor's understanding of how the audit was conducted and/or how the audit findings were derived. Any such request for clarification shall be in writing from the Contractor to the Department.

If the Contractor disagrees with the audit findings, the Contractor may signify its disagreement by submitting a claim in writing to the Department as provided for in Article VIII.

E. CONTRACT ADMINISTRATION

The Department shall designate a Contract Administrator to act as liaison between the Contractor and the Department. The administrator shall be responsible for:

a. Representing the Department on matters pertaining to the Contract.

b. Receiving and responding to inquiries and requests made by the Contractor, under the Contract, in an expeditious manner.

c. Meeting with the Contractor's representatives on a periodic or as-needed basis and resolving issues that arise.

d. Coordinating requests and activities from the Contractor to ensure that Department staff with appropriate expertise in clinical, financial data, and marketing/enrollment matters are involved in Contractor initiatives and quality improvement goals.

e. Making best efforts to resolve any issues identified either by the Contractor or the Department that may arise that are applicable to the Contract.

f. Monitoring compliance with the terms of this Contract.

F. READINESS REVIEW

The Department or its duly authorized representative may conduct a readiness review, which will include a minimum of one site visit for each MCO that contracts with the Department. This review may be conducted prior to enrollment of any FAMIS enrollees in the MCO and prior to the renewal of the Contract and shall commence within thirty (30) calendar days of the execution of this Contract. The purpose of the review is to provide the Department with assurances that the MCO is able and prepared to perform all administrative functions and to provide high-quality services to enrolled enrollees.

Specifically, the review will document the status of the MCO with respect to meeting program standards set forth in this Contract, as well as any goals established by the MCO. The readiness review activities will be conducted by a multidisciplinary team appointed by the Department. The scope of the readiness review will include, but not be limited to, review and/or verification of: network provider composition and access; staffing; content of provider agreements; high-risk perinatal plan; financial solvency; and information systems performance and interfacing capabilities. The readiness review may assess the Contractor's ability to meet any requirements set forth in this Contract and the documents referenced herein.

Enrollees may not be enrolled in an MCO until the Department has determined that the MCO is capable of meeting these standards. A Contractor's failure to pass the readiness review within ninety (90) calendar days of the execution of this Contract may result in contract termination.

The Department will provide the Contractor with a summary of the findings as well as areas requiring remedial action.

G. CONTRACT MONITORING

The Department's Contract Administrator shall be responsible for conducting an ongoing contract monitoring process. As part of this monitoring process, the Department shall review the performance of the Contractor in relation to the performance standards outlined in this Contract, in the proposal submitted in response to the RFP, and in the RFP. The Department may, at its sole discretion, conduct any or all of the following activities as part of the contract monitoring process:

a. Collect and review standard hard copy and electronic reports and related documentation, including encounter data, which the Contractor is required, under the terms of this Contract, to submit to the Department or otherwise maintain;

b. Conduct MCO, network provider, and subcontractor site visits; and

c. Review MCO policies and procedures and other internal documents.

During the conduct of contract monitoring activities, the Department may assess the Contractor's compliance with any requirements set forth in this contract and in the documents referenced herein.

ARTICLE IV - PAYMENTS TO AND FROM THE MCO

A. PAYMENT TO MCOs

The Department shall issue capitation payments on behalf of enrollees at the rates established in this Contract and modified during the contract renewal process. The Department shall be responsible for issuing capitation payments to the MCOs. The Contractor shall accept the capitation rate paid as specified by the Department, from the Department as payment in full for all services to be provided pursuant to this Contract and all administrative costs associated therewith, pending final recoupments, reconciliation, or sanctions. Any and all costs incurred by the Plan in excess of the capitation payment will be borne in full by the Plan. The Contractor shall accept the Department's electronic transfer of funds to receive capitation payments,

B. REINSURANCE

The Contractor shall obtain reinsurance from an insurer other than the Department for coverage of enrollees under this Contract.

C. RECOUPMENT/RECONCILIATION

The Department shall recoup an enrollee's capitation payment for a given month in cases in which an enrollee's exclusion or disenrollment was effective retroactively. The Department shall not recoup an enrollee's capitation payment for a given month in cases in which an enrollee is eligible for any portion of the month. .

This provision applies to cases where the eligibility or exclusion can occur throughout the month including but not limited to: death of an enrollee, cessation of FAMIS eligibility.

The Department shall recoup capitation payments made in error by the Department.

When membership is disputed between two Contractors, the Department shall be the final arbitrator of Contractor enrollment and reserves the right to recoup an inappropriate capitation payment.

The Contractor shall not be liable for the payment of any services covered under this Contract rendered to an enrollee after the effective date of the enrollee's exclusion or disenrollment.

If this Contract is terminated, recoupments shall be handled through a payment by the Contractor within thirty (30) calendar days after contract termination or thirty (30) calendar days following determination of specific recoupment requirements, whichever comes last.

The Department shall reconcile payments on a quarterly basis. Included in the quarterly reconciliation shall be additional payments for newborns enrolling with the Contractor and other adjustments that may be required in accordance with the terms of this contract. This reconciliation shall be based on adjustments known to be needed through the end of the quarter.. If reconciliation withholdings exceed reconciliation payments, the Department may, at its option, withhold from subsequent monthly payments or bill the Contractor for the difference, in which case the Contractor shall provide payment within thirty (30) calendar days of the bill date. Payments shall not be made for periods greater than twenty-four (24) months prior to the date of reconciliation. The Department has devised the following schedule for timely submission of payment for newborns.

Babies Born in:	For whom the MCO has not received payment by:	Should be reported to the Department by:
Jan, Feb, March	September 15	October 1
Apr, May, June	December 15	January 1
July, Aug, Sept	March 15	April 1
Oct, Nov, Dec	June 15	July 1

D. THIRD-PARTY LIABILITY (TPL)

1. Comprehensive Health Coverage

Individuals enrolled in FAMIS, determined by the Department as having comprehensive health coverage, except for FAMIS enrollees under the Employer Sponsored Health Insurance program, will not be eligible for FAMIS.

Under section 1902 (a)(25) of the Social Security Act, (42 U.S.C. §1396 a (a)(25)) the State is required to take all reasonable measures to identify legally liable third parties and pursue verified resources. In cases in which the enrollee was not identified for exclusion prior to enrollment in the MCO, the Contractor shall take responsibility for identifying and pursuing comprehensive health coverage. Any moneys recovered by third parties shall be retained by the Contractor and identified monthly to the Department. The Contractor shall notify the Department or its designated agent on a monthly basis of any enrollees identified during that past month who were discovered to have comprehensive health coverage.

2. Workers' Compensation

If an enrollee is injured at his or her place of employment and files a workers' compensation claim, the Contractor shall remain responsible for all services. The Contractor may seek recoveries from a claim covered by workers' compensation if the Contractor actually reimbursed providers and the claim is approved for the workers' compensation fund. The Contractor shall notify DMAS on a monthly basis of any enrollees identified during that past month who are discovered to have workers' compensation coverage.

If the enrollee's injury is determined not to qualify as a worker's compensation claim, the Contractor shall be responsible for all services provided while the injury was under review, even if the services were provided by out-of-network providers, in accordance with worker's compensation regulations.

3. Other Coverage

The Department retains the responsibility to pursue, collect, and retain all non-health insurance resources, such as casualty, liability, estates, child support, and personal injury claims. The Contractor is not permitted to seek recovery of any non-health insurance funds.

Individuals with these other resources shall remain enrolled in the MCO. The Contractor shall notify the Department or its designated agent on a monthly basis of any enrollees identified during that past month who are discovered to have any of the above coverages, including enrollees identified as having trauma injuries.

E. PAYMENT USING DRG METHODOLOGY

If the MCO has a contract with a facility to reimburse the facility for services rendered to its members based on a Diagnosis Relative Grouping (DRG) payment methodology, the MCO is responsible for the full inpatient hospitalization from admission to discharge. This will be effective for any member who is actively enrolled in the MCO on the date of admission regardless if the member is disenrolled from the MCO during the course of the inpatient hospitalization.

F. PAYMENTS FOR NEWBORNS

Until such time that a newborn is assigned a FAMIS/FAMIS Plus identification number, the charges for newborns to mothers enrolled with the Contractor are the responsibility of the Contractor. Where enrollment errors occur that are later corrected, regardless of the time frame to correct such error, the Contractor is required to cover the newborn recipient and related charges. The Department will reimburse the Contractor the appropriate capitation payment

G. LIMIT ON UNDERWRITING GAIN

The Contractor shall be subject to a maximum underwriting gain expressed as a percentage of Medicaid premium income equal to 8.00%. The percentage shall be determined as the ratio of Medicaid underwriting gain to the amount of Medicaid premium income for the calendar year as reported in the Contractor's Annual Financial Statement filed with the Virginia Bureau of Insurance. If the ratio for calendar year 2007 exceeds 8.00% then the Contractor shall make payment to the Department equal to the excess percentage applied to the amount of Medicaid premium income attributable to the FAMIS contract, as a refund of an overpayment.

Medicaid underwriting gain shall be the amount reported on the Analysis of Operation by Lines of Business (Gain and Loss Exhibit) line 24 under the column entitled Title XIX Medicaid. Medicaid premium income shall be the amount reported on the Analysis of Operation by Lines of Business (Gain and Loss Exhibit) line 1 under the column entitled Title XIX Medicaid.

The limit on underwriting gain will not apply for a given calendar year if the Contractor has fewer than 120,000 member months during the calendar year. The number of member months for a given calendar year shall be the amount reported on the Exhibit of Premiums, Enrollment and Utilization line 6 under the column entitled Title XIX Medicaid. In addition, the limit on underwriting gain shall not apply to a Contractor for a given calendar year if the Contractor has less than 12 months of experience in the Medallion II program at the beginning of the calendar year.

If the Contractor is required to make a payment to the Department under this contract provision, the payment shall be due to the Department no later than June 1 of the following calendar year.

The Contractor is prohibited from providing bonus and/or incentive payments to contracted providers or subcontractors which are determined based upon the applicability of this contract provision.

ARTICLE V - REMEDIES FOR VIOLATION, BREACH, OR NON-PERFORMANCE OF CONTRACT

Upon receipt by the Department of evidence of substantial non-compliance by the Contractor with any of the provisions of this Contract, the following remedies may be imposed.

A. PROHIBITION AGAINST CONTRACTING WITH EXCLUDED PROVIDERS

The Contractor (which shall include its subcontractors) must ensure that providers in their networks are licensed by the State and have received proper certification or training to perform the specific services for which they are contracted. Network providers must also be in good standing with the Department programs or applicable licensing board.

In accordance with 1902(a)(39) and (41), 1128, and 1128A of the Social Security Act, 42 CFR § 438-610, 42 CFR §1002, and 12VAC30-10-690 of the Virginia Administrative Code and other applicable federal and state statutes and regulations, the Contractor shall neither participate with nor enter into any provider agreement with any individual or entity that has been excluded from participation in federal health care programs.

Federal health care programs include Medicare, Medicaid, and all other plans and programs that provide health benefits funded directly or indirectly by the United States. A searchable database of persons excluded from participation can be found at http://www.oig.hhs.gov/fraud/exclusions/listofexcluded.html.

The Contractor is prohibited from contracting with providers who have been terminated from the Medicaid or FAMIS programs by DMAS for fraud and abuse.

The Contractor's standards for licensure and certification shall be included in its participating provider network agreements.

The Contractor shall have written policies and procedures for their provider enrollment and/or credentialing process. The Contractor shall perform, at a minimum, an annual review on all providers to ensure that their contracted health care professionals have not been included on the federal database of excluded providers.

The Contractor must have in place a mechanism for reporting to the Department and any appropriate authorities all actions that seriously impact quality of care and which may result in suspension or termination of a practitioner's license. The Contractor also must report to the Department within five business days of discovery of any network providers that have been identified on the federal database of excluded providers and the action taken by the Contractor. The Contractor shall submit a copy of the policies and procedures to the Department annually or in the event of any modifications to the process or standards.

B. PROCEDURE FOR CONTRACTOR NONCOMPLIANCE NOTIFICATION

In the event that the Department identifies or learns of noncompliance with the terms of this contract the Department will notify the Contractor in writing of the nature of the noncompliance. The Contractor must remedy the noncompliance within a time period established by the Department and the Department will designate a period of time, not less than ten (10) calendar days, in which the Contractor must provide a written response to the notification. The Department may develop or may require the Contractor to develop procedures with which the Contractor must comply to eliminate or prevent the imposition of specific remedies.

C. SPECIFIC COMPLIANCE EMPHASIS

The Department requires strict compliance with all contract provisions. It places particular emphasis on prompt, accurate, and complete compliance with requirements related to the following:

- access to medical services
- quality
- network access
- marketing activities;
- issuance of enrollee ID cards;
- submission of encounter data;
- submission of requested medical records;
- submission of required reports; And
- abuse

Contractors may expect the prompt imposition of stringent remedies for failure to comply with contractual requirements associated with these priority items.

D. REMEDIES AVAILABLE TO THE DEPARTMENT

The Department reserves the right to employ, at the Department's sole discretion, any of the remedies and sanctions set forth below and to resort to other remedies provided by law. In no event may the application of any of the following remedies preclude the Department's right to any other remedy available in law or regulation.

1. Remedies

In the event of any breach of the terms of the Contract by the Contractor, the Contractor shall pay damages to the Department for such breach at the sole discretion of the Department, at a minimum, according to the following subsections.

If, in a particular instance, the Department elects not to exercise a damage clause or other remedy contained herein, this decision shall not be construed as a waiver of the Department's right to pursue future assessment of that performance requirement and

associated damages, including damages that, under the terms of the RFP or Contract, may be retroactively assessed.

a. Sanctions For Noncompliance

The State may impose the following civil money penalties:

(1) for each determination that the managed care organization (MCO) fails to substantially provide medically necessary services or fails to comply with the physician incentive plan requirements, not more than $25,000.

(2) for each determination that the MCO discriminates among enrollees on the basis of their health status or requirements for health care services or engages in any practice that has the effect of denying or discouraging enrollment with the entity by eligible individuals based on their medical condition or history that indicates a need for substantial future medical services, or the MCO misrepresents or falsifies information furnished to the Secretary of Health and Human Services, State, enrollee, potential enrollee, or health care provider, not more than $100,000.

(3) for each determination that the MCO has discriminated among enrollees or engaged in any practice that has denied or discouraged enrollment, the money penalty may be as high as $15,000 for each individual not enrolled as a result of the practice, up to a total of $100,000.

b. Remedies for Contracted Services

If the Department determines that the Contractor failed to provide one (1) or more of the contract services required under the contract, or that the Contractor failed to maintain or make available any records or reports required under the Contract by the Department which the Department may use to determine whether the Contractor is providing contract services as required, the following remedies may be imposed:

(1) The State may terminate contracts of any managed care organization that has failed to meet the requirements of the contract, State or Federal requirements, or quality requirements, or that has failed to provide contracted services.

(2) The State **must** give the managed care organization a hearing before termination occurs and the State **must** notify the individuals enrolled with the managed care organization of the hearing and allow the enrollees to disenroll if they choose without cause.

(3) The State may suspend or stop all enrollments of FAMIS enrollees after the date the Secretary of Health and Human Services or the State notifies the entity of a violation determination. The Department may make this remedy applicable to specific populations served by the Contractor or the entire contracted area. The Department, when exercising this option, must notify the Contractor in writing of its intent to suspend FAMIS enrollment at least thirty (30) calendar days prior to the beginning of the suspension period. The suspension period may be for any length of time specified by the Department, or may be indefinite. The Department may also suspend FAMIS enrollment or disenroll FAMIS enrollees in anticipation of the Contractor not being able to comply with any requirement of this Contract or with federal or State laws or regulations at its current enrollment level. Such suspension shall not be subject to the thirty (30) calendar day notification requirement.

The Department also may notify FAMIS enrollees of Contractor non-compliance and provide such enrollees an opportunity to enroll with another MCO.

(4) Department-Initiated Disenrollment

The State may permit individuals enrolled in an MCO to disenroll without cause. The Department may reduce the number of current enrollees by disenrolling the Contractor's FAMIS enrollees. The Contractor shall be given at least thirty (30) calendar days notice prior to the Department taking any action set forth in this paragraph.

(5) Suspension of Marketing Services and Activities

The Department may suspend a Contractor's marketing activities that are geared toward potential FAMIS enrollees. The Contractor shall be given at least ten (10) calendar days notice prior to the Department taking any action set forth in this paragraph.

c. Withholding of Capitation Payments and Recovery of Damage Costs

When the Department withholds payments under this section, the Department must submit to the Contractor a list of the enrollees for whom payments are being withheld, the nature of the services denied, and payments the Department must make to provide medically necessary services. In any case under this Contract where the Department has the authority to withhold capitation payments, the Department also has the authority to use all other legal processes for the recovery

of damages. The Department may withhold portions of capitation payments or otherwise recover damages from the Contractor in the following situations:

i. Whenever the Department determines the Contractor failed to provide one (1) or more of the medically necessary FAMIS covered contract services, the Department may direct the Contractor to provide such service or withhold a portion of the Contractor's capitation payments for the following month or subsequent months, such portion withheld to be equal to the amount of money the Department must pay to provide such services. The Contractor shall be given at least seven (7) calendar days written notice prior to the withholding of any capitation payment.

ii. Whenever the Department determines that the Contractor has failed to perform an administrative function required under the Contract, the Department may withhold a portion of future capitation payments to compensate for the damages that this failure entails. For the purposes of this section, "administrative function" is defined as any contract service.

iii. In any case where the Department intends to withhold capitation payments or recover damages through the exercise of other legal processes, the following procedures shall be used:

(a) The Department shall notify the Contractor of the Contractor's failure to perform required administrative functions under the Contract.

(b) The Department shall give the Contractor thirty (30) calendar days notice to develop an acceptable plan for correcting this failure.

(c) If the Contractor has not submitted an acceptable correction action plan within thirty (30) calendar days, or has not implemented this plan within the timeframe in the approved action plan, the Department will provide the Contractor with a written document itemizing the damage costs for which it intends to require compensation seven (7) calendar days prior to withholding any capitation payment. The Department shall then proceed to recover said compensation.

(d) The Department shall notify the Contractor when it is determined that the Contractor is not in compliance with a provision in this contract. Notice shall be sent requesting a corrective action plan to resolve the error. If the Contractor fails to

respond to the Department's request in three (3) business days, the Department shall notify the Contractor in writing of its failure to respond to the Department is a violation of this contract. If the Contractor continues to withhold corrective action within one (1) week of the date of the letter, the Department's Director shall notify the Contractor that its continued failure to act will result in one or a combination of the following remedies to the Department:

1. withhold of capitation;
2. withhold/suspension of future enrollment;
3. fines for violation not to exceed $10,000 per occurrence; and/or
4. termination of the contract

d. Probation

The Department may place a Contractor on probation, in whole or in part, if the Department determines that it is in the best interest of FAMIS enrollees and the Department. The Department may do so by providing the Contractor with a written notice explaining the terms and the time period of the probation. The Contractor shall, immediately upon receipt of such notice, provide services in accordance with the terms set forth and shall continue to do so for the period specified or until further notice. When on probation, the Contractor shall work in cooperation with the Department, and the Department may institute ongoing review and approval of Contractor FAMIS activities.

e. Suspension of Contractor Operations

The Department may suspend a Contractor's FAMIS operations, in whole or in part, if the Department determines that it is in the best interest of FAMIS enrollees to do so. The Department may do so by providing the Contractor with written notice. The Contractor shall, immediately upon receipt of such notice, cease providing services for the period specified in such notice, or until further notice.

f. Remedies not Exclusive

The remedies available to the Department as set forth above are in addition to all other remedies available to the Department in law or in equity, are joint and severable and may be exercised concurrently or consecutively. Exercise of any remedy in whole or in part shall not limit the Department in exercising all or part of any other remedies.

E. APPEAL RIGHTS OF THE CONTRACTOR

For violations set forth in *Code of Virginia* §32.1-137.5 the Department may impose the sanctions provided therein.

The Contractor shall have all the appeal rights provided for in § 32.1-137.5 and §§ 2.2-4019 and 2.2-4025 et seq. of the Code of Virginia.

For all other sanctions the Contractor shall have the appeal rights provided for in the Virginia Public Procurement Act, § 2.2-4365 et seq. of the *Code of Virginia*.

F. ATTORNEY FEES

In the event the Department shall prevail in any legal action arising out of the performance or non-performance of this Contract, the Contractor shall pay, in addition to any damages, all expenses of such action including reasonable attorney's fees and costs. The term "legal action" shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

ARTICLE VI - CONTRACT TERM AND RENEWAL

The effective date of this Contract is July 1, 2007. This Contract will be effective until June 30, 2008.

The Contract shall automatically renew for six additional months if, on the ending date of this Contract, the Contractor and the Department are actively involved in good faith renegotiations of this Contract or negotiation of another risk based Contract. The capitation rates for this automatic renewal period will be set at the discretion of the Department.

The Contractor may opt out of the above automatic renewal clause. In order to do so, the Contractor must notify the Department in writing at least six (6) full months prior to the renewal. If the Contractor fails to notify the Department of non-renewal on or before this date, the Contract will be automatically renewed.

ARTICLE VII - TERMINATION

A. TERMINATION

This Contract may be terminated in whole or in part:

a. By the Department or the Contractor, for convenience, with 180 days advance written notice,

b. By the Department, in whole or in part, if funding from Federal, State, or other sources is withdrawn, reduced, or limited;

c. By the Department if the Department determines that the instability of the Contractor's financial condition threatens delivery of FAMIS services and continued performance of the Contractor's responsibilities; or

d. By the Department if the Department determines that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities.

Each of these conditions for contract termination is described in the following paragraphs.

1. Termination for Convenience

The Department may terminate this Contract with or without cause upon 120 calendar days written notice to the Contractor.

The Contractor may terminate this Contract with or without cause, upon six (6) full months written notice to the Department. In addition, the Contractor may terminate the Contract, as provided in Article VI of this Contract, by opting out of the renewal clause.

2. Termination for Unavailable Funds

The Contractor understands and agrees that the Department shall be bound only to the extent of the funds available or which may become available for the purpose of this resulting Contract. When the Department makes a written determination that funds are not adequately appropriated or otherwise unavailable to support continuance of performance of this Contract, the Department shall, in whole or in part, cancel or terminate this Contract.

The Department's payment of funds for purposes of this Contract is subject to and conditioned upon the availability of funds for such purposes, whether Federal and/or State funds. The Department may terminate this Contract upon written notice to the Contractor at any time prior to the completion of this Contract, if, in the sole opinion of

the Department, funding becomes unavailable for these services or such funds are restricted or reduced. In the event that funds are restricted or reduced, it is agreed by both parties that, at the sole discretion of the Department, this Contract may be amended. Shall the Contractor be unable or unwilling to provide covered services at reduced capitation rates, the Contract shall be terminated.

No damages, losses, or expenses may be sought by the Contractor against the Department, if, in the sole determination of the Department, funds become unavailable before or after this Contract between the parties is executed. A determination by the Department that funds are not appropriated or are otherwise inadequate or unavailable to support the continuance of this Contract shall be final and conclusive.

3. Termination Because of Financial Instability

In the event the Contractor becomes financially unstable to the point of threatening the ability of the Department to obtain the services provided for under the Contract, ceases to conduct business in normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or assets, the Department may, at its option, immediately terminate this Contract effective at the close of business on a date specified by the Department. In the event the Department elects to terminate the Contract under this provision, the Contractor shall be notified in writing, by either certified or registered mail, specifying the date of termination. The Contractor shall submit a written waiver of the licensee's rights under the Federal bankruptcy laws.

In the event of the filing of a petition in bankruptcy by a principal network provider (a provider whose termination impacts the MCO's ability to arrange covered services consistent with network and access standards detailed in Article II) or subcontractor, the Contractor shall immediately so advise the Department. The Contractor shall ensure that all tasks that have been delegated to its subcontractor(s) are performed in accordance with the terms of this Contract.

4. Termination for Default

The Department may terminate the Contract, in whole or in part, if the Department determines that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract and is unable to cure such failure within a reasonable period of time as specified in writing by the Department, taking into consideration the gravity and nature of the default. Such termination shall be referred to herein as "Termination for Default."

Upon determination by the Department that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract, the Contractor shall be notified in writing, by either certified or registered mail, of the failure and of the time period which has been established to cure such failure. If the Contractor is unable to cure the failure within the specified time period, the Department will notify the Contractor in writing within thirty (30) calendar days of the last day of the specified time period that

the Contract, has been terminated in full or in part, for default. This written notice will identify all of the Contractor's responsibilities in the case of the termination, including responsibilities related to enrollee notification, network provider notification, refunds of advance payments, and liability for medical claims.

If, after notice of termination for default, it is determined by the Department or by a court of law that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control of and without error or negligence on the part of the Contractor or any of its subcontractors, the notice of termination shall be deemed to have been issued as a termination for the convenience of the Department, and the rights and obligations of the parties shall be governed accordingly.

In the event of termination for default, in full or in part, as provided for under this clause, the Department may procure from other sources, upon such terms and in such manner as is deemed appropriate by the Department, supplies or services similar to those terminated, and the Contractor shall be liable for any costs for such similar supplies and services and all other damages allowed by law. In addition, the Contractor shall be liable to the Department for administrative costs incurred to procure such similar supplies or services as are needed to continue operations. In the event of a termination for default prior to the start of operations, any claim the Contractor may assert shall be governed by the procedures defined by the Department for handling contract termination. Nothing herein shall be construed as limiting any other remedies which may be available to the Department.

In the event of a termination for default during ongoing operations, the Contractor shall be paid for any outstanding capitation payments due less any assessed damages.

B. TERMINATION PROCEDURES

1. Liability for Medical Claims

The Contractor shall be liable for all medical claims incurred up to the date of termination. This shall include all of the hospital inpatient claims incurred for enrollees hospitalized at the time of termination.

2. Refunds of Advanced Payments

If the Contract is terminated under this article, the Contractor shall be entitled to be paid a pro-rated capitation amount for the month in which notice of termination was effective to cover the services rendered to enrollees prior to the termination. The Contractor shall not be entitled to be paid for any services performed after the effective date of the termination. The Contractor shall, within thirty (30) calendar days of receipt, return any funds advanced for coverage of enrollees for periods after the date of termination of the Contract.

3. Notification of Enrollees

In all cases of termination, the Contractor shall be responsible for notifying enrollees about the termination and the Department shall be responsible for reassigning enrollees to new MCOs, as appropriate. In cases of termination for default or financial instability, the Contractor shall be responsible for covering the costs associated with such notification. In cases of termination for convenience, the costs associated with such notification shall be the responsibility of the party that terminated the Contract. In cases of termination due to unavailability of funds or termination in the best interest of the Department, the Department shall be responsible for the costs associated with such notification. The Contractor shall conduct these notification activities within a time frame established by the Department.

4. Notification of Network Providers

In all cases of termination, the Contractor shall be responsible for notifying its network providers about the termination of the FAMIS Contract and about the reassigning of its enrollees to other MCOs and for covering the costs associated with such notification. The Contractor shall conduct these notification activities within a time frame established by the Department.

5. Other Procedures on Termination

Upon delivery by certified or registered mail to the Contractor of a Notice of Termination specifying the nature of the termination and the date upon which such termination becomes effective, the Contractor shall:

a. Stop work under the Contract on the date specified and to the extent specified in the Notice of Termination;

b. Place no further orders or subcontracts for materials, services, or facilities;

c. Terminate all orders, provider network agreements and subcontracts to the extent that they relate to the performance of work terminated by the Notice of Termination;

d. Within ten (10) business days from the effective date of termination, transfer title to the State (to the extent that the title has not already been transferred) and deliver, in the manner and to the extent directed, all data, other information, and documentation, in any form that relates to the work terminated by the Notice of Termination;

e Complete the performance of such part of the work as has not been specified for termination by the Notice of Termination;

f. Take such action as may be necessary, or as the Department may direct, for the protection and preservation of the property which is in the possession of the Contractor and in which the Department has acquired or may acquire interest; and

g. Assist the Department in taking the steps necessary to assure an orderly transition of requested services after receipt of Notice of Termination.

The Contractor hereby acknowledges that any failure or unreasonable delay on its part in affecting a smooth transition will cause irreparable injury to the State that may not be adequately compensable in damages. The Contractor agrees that the Department may, in such event, seek and obtain injunctive relief, as well as monetary damages. Any payments made by the Department pursuant to this section may also constitute an element of damages in any action in which Contractor fault is alleged.

The Contractor shall proceed immediately with the performance of the above obligations, notwithstanding any delay in determining or adjusting the amount of any item of reimbursable price under this clause.

Upon termination of this Contract in full, the Department shall require the Contractor to return to the Department any property made available for its use during the Contract term.

ARTICLE VIII - DISPUTES

A. RIGHT TO APPEALS

The Contractor shall have the right to appeal any adverse action taken by the Department. All appeals arising out of a sanction or remedy levied pursuant to Article V of this Contract shall be handled in accordance with Article V.

For appeals not addressed by Article V, the Contractor shall proceed in accordance with the appeals provisions in the *Code of Virginia,* § 11-35, as amended, *et seq*. (the Virginia Public Procurement Act). Pursuant to the *Code of Virginia* §§ 11-70 and 11-71, as amended, the Department establishes an administrative appeals procedure, under which the Contractor may elect to appeal decisions on disputes arising during the performance of its Contract. In conducting the administrative appeal, the hearing officer shall follow the hearing procedure like that in *Code of Virginia* § 9-6.14:12, as amended.

The Contractor may not submit to the Department for resolution under this section disputes relating to FAMIS eligibility requirements, or FAMIS covered services.

B. DISPUTES ARISING OUT OF THE CONTRACT

As provided for in *Code of Virginia* § 11-69, as amended, disputes arising out of the Contract, whether for money or other relief, are to be submitted by the Contractor for consideration by the Department. Disputes must be submitted in writing, with all necessary data and information, to the Contract Administrator or designee.

Disputes will not be considered if submitted later than sixty (60) calendar days after the date on which the Contractor knew of the occurrence giving rise to the dispute or the beginning date of the work upon which the dispute is based, whichever is earlier. Further, no claim may be submitted unless written notice of the Contractor's intention to file the dispute has been submitted at least thirty (30) calendar days prior to a formal filing of the dispute, and such thirty (30) calendar days is to be counted from the date of the occurrence or the beginning date of the work upon which the dispute is based, whichever is earlier.

C. INFORMAL RESOLUTION OF DISPUTES ARISING OUT OF THE CONTRACT

For any dispute arising out of the Contract, except for any dispute resulting from any breach of statute or regulation, the parties shall first attempt to resolve their differences informally. Should the parties fail to resolve their differences after good-faith efforts to do so, then the parties may proceed with formal avenues for resolution of the dispute.

D. PRESENTATION OF DOCUMENTED EVIDENCE

The Contractor is obligated to present to the Department all witnesses, documents, or other evidence necessary to support its claim. Evidence that the Contractor has but fails to present to the Department will be deemed waived and may not be presented to the Circuit Court.

The Contractor shall have the burden of proving to the Department by a preponderance of the evidence that the relief it seeks should be granted.

ARTICLE IX - SECURITY AND CONFIDENTIALITY OF RECORDS

A. USE OR DISCLOSURE OF INFORMATION

The use or disclosure of information concerning Contract services or enrollees obtained in connection with the performance of this Contract shall be in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule requirements and the State Plan and is restricted to purposes directly related to the administration and the provision of services provided under this Contract.

1. Disclosure and Confidentiality

The Contractor must have a confidentiality agreement in place with individuals of its workforce who have access to PHI. A sample Authorized Workforce Confidentiality Agreement is included as Attachment X of this contract. Issuing and maintaining these confidentiality agreements will be the responsibility of the Contractor. The Department shall have the option to inspect the maintenance of said confidentiality agreements.

2. Disclosure to Workforce

The Contractor shall not disclose PHI to any member of its workforce except to those persons who have authorized access to the information, who have received privacy training in PHI and who have signed an agreement to hold the information in confidence.

The Contractor understands and agrees that data, materials, and information disclosed to the Contractor may contain confidential and protected data. The Contract, therefore, must ensure that data, material, and information gathered, based upon or disclosed to the Contractor for the purpose of this Contract, shall not be disclosed to others or discussed with other outside parties without the prior written consent of the Commonwealth of Virginia.

3. Safeguards

The Contractor shall implement and maintain appropriate safeguards to prevent the use and disclosure of protected health information (PHI), other than as provided in this Contract. A description of such safeguards in the form of a contractor Data Security Plan (DSP). A sample DSP is included as Attachment X to this contract. Upon reasonable request, the Contractor shall give the Department access for inspection and copying to the Contractor's facilities used for the maintenance or processing of PHI, and books, records, practices, policies and procedures concerning the use and disclosure of PHI, including DSPs, for the purpose of determining the Contractor's compliance with this agreement.

4. Accounting of Disclosures

The Contractor shall maintain an ongoing log of the details relating to any disclosures of PHI it makes (including but not limited to, the date made, the name of the person or organization receiving the PHI, the recipient's address, if known, a description of the PHI disclosed, and the reason for the disclosure), as required by 45 CFR 164.528. The Contractor shall, within thirty (30) days of The Department's request, make such log available to the Department, as needed for the Department to provide a proper accounting of disclosures to its patients.

5. Disclosure to the U.S. Department of Health and Human Services

The Contractor shall make its internal practices, books, and records relating to the use and disclosure of PHI received from the Department (or created or received by the Contractor on behalf of the Department) available to the Secretary of the Department of Health and Human Services (DHHS) or its designee for purposes of determining the Contractor's compliance with HIPAA and with the Privacy Regulations issued pursuant thereto. The Department shall provide the Contractor with copies of any information it has made available to DHHS under this section of this contract.

6. Reporting

The Contractor shall report to the Department within thirty (30) days of discovery, any use or disclosure of PHI made in violation of this Contract or any law. The Contractor shall implement and maintain sanctions for any employee, subcontractor, or agent who violates the requirements in this Contract or the HIPAA privacy regulations. The Contractor shall, as requested by the Department, take steps to mitigate any harmful effect of any such violation of this Contract.

7. Access to PHI

The Contractor shall make an individuals PHI available to the Department within thirty (30) days of an individuals request for such information as notified and in the format requested by the Department.

8. Amendment to PHI

The Contractor shall make PHI Available to amendment and correction and shall incorporate any amendments or corrections to PHI within (30) days of notification by the Department.

The Contractor hereby agrees to comply with the terms set forth in the Department's Confidentiality Agreement, Attachment IX.

B. ACCESS TO CONFIDENTIAL INFORMATION

Except as otherwise required by law, including, but not limited to, the Virginia Freedom of Information Act, access to confidential information shall be limited by the Contractor and the Department to persons who or agencies which require the information in order to perform their duties related to this Contract, including the United States Department of Health and Human Services; the Office of the Attorney General of the Commonwealth of Virginia, including the FAMIS Fraud Control Unit; and such others as may be required by the Department.

In complying with the requirements of this section, the Contractor and the Commonwealth shall follow the requirements of 42 CFR Part 431, Subpart F, as amended, regarding confidentiality of information concerning applicants and enrollees of public assistance, and 42 CFR Part 2, as amended, regarding confidentiality of alcohol and drug abuse patient records.

The Contractor must have written policies and procedures for maintaining the confidentiality of data, including medical records and enrollee information and appointment records for treatment of sexually transmitted diseases and submit such policies and procedures annually to the Department.

The Contractor shall comply with the Department's Security Requirements for Vendors.

C. DATA SECURITY PLAN

By executing this Contract, the Contractor agrees to work with the Department's HIPAA Office of Privacy and Security to create a Data Security Plan governing the Contractor's use of Department data. Attachments X summarizes the basic requirements for such a Data Security Plan, the final contents of which will be negotiated between the Contractor and the Department's HIPAA Office of Privacy and Security

D. AUDITS, INSPECTIONS AND ENFORCEMENT

With reasonable notice, the Department may inspect the facilities, systems, books and records of the Contractor to monitor compliance with HIPAA. The Contractor shall promptly remedy any violation of any term of HIPAA and shall certify the same to the Department in writing. The fact the Department inspects, or fails to inspect, or has the right to inspect, the Contractor's facilities, systems and procedures does not relieve the Contractor of its responsibility to comply with HIPAA, nor does the Department's failure to detect, or to detect but fail to call the Contractor's attention to or require Remediation of any unsatisfactory practice constitute acceptance of such practice or waiving of the Department's enforcement rights.

The Department may terminate the Agreement without penalty if the Contractor repeatedly violates HIPAA or any provision hereof, irrespective of whether, or how promptly, the Contractor may remedy such violation after being notified of the same. In case of any such termination, the Department shall not be liable for the payment of any

services performed by the Contractor after the effective date of the termination, and the Department shall be liable to the Contractor in accordance with the Agreement for services provided prior to the effective date of termination.

The Contractor acknowledges and agrees that any individual who is the subject of PHI disclosed by the Department to the Contractor is a third party beneficiary of HIPAA and may, to the extent otherwise permitted by law, enforce directly against the Contractor any rights such individual may have under this HIPAA, the Agreement, or any other law, relating to or arising out of the Contractor's violation of any provision of HIPAA.

ARTICLE X - DOCUMENTS CONSTITUTING THE CONTRACT

A. DOCUMENTS THAT CONSTITUTE THE CONTRACT

The documents that constitute this Contract are the following:

a. This document;

b. Subsequent modifications approved in writing by the Contractor and the Department.

In addition, the Contract hereby incorporates the following attachments:

i. TPL Other Coverage Monthly
ii. FAMIS Covered Services
iii. Provider File Data Requirements
iv. Network Provider Agreement
v. Inquiry, Complaint, Grievance, and Appeals Summary Form
vi. Reporting Requirements
vii. Hospital Inpatient Days Report Form
viii. Live Birth Outcomes Report
ix. Confidentiality Agreement Format for Data Security Plan
x. Third Party Accident Reports
xi. Complaint, Grievance, Appeals Reason Codes
xii. FAMIS Newborn Reports
xiii. FAMIS Enrollee Address Change Report
xiv. Authorized Workforce Confidentiality Agreement
xv. Monthly EDI Report
xvi. Certification of Encounter Data
xvii. Certification of Data
xviii. Certification of Non-Encounter Data
xix. DMAS Managed Care Expansion Requirements
xx. MCO Specific Contract Terms

B. ORDER OF PRECEDENCE

The documents listed above shall constitute the entire Contract between the parties, and no other expression, whether oral or written, shall constitute any part of this Contract. Any conflict, inconsistency, or ambiguity among the contract documents shall be resolved by giving legal order of precedence in the following order:

a. Federal Laws and Regulations
b. FAMIS State Child Health Plan
c. FAMIS State Regulations
d. FAMIS MCO Contract
e. Attachments submitted by the Contractor

Any ambiguity in the interpretation of this Contract shall be resolved in accordance with the requirements of Federal and Virginia laws and regulations, including the FAMIS State Plan and Department memos, notices, and provider manuals.

Services listed as covered in any evidence of coverage or any enrollee handbook shall not take precedence over the services required under this Contract or the FAMIS State Plan.

ARTICLE XI - MISCELLANEOUS

A. AGREEMENT TO TERMS AND CONDITIONS

Through submittal of the response of the Department's request for Proposals and by signing this Contract, the Contractor shall accept and agree to all of the terms, conditions, criteria, and requirements set forth in these documents and their attachments. Acceptance of the terms and conditions shall serve as a waiver of any and all objections by the Contractor as to the contents of the Department's RFP and this Contract.

The Contractor may request to be exempted from any contract requirement; however, such request for exemption must be requested in writing and in advance of the contract effective date. Any release by the Department of any contractual requirement must be approved by the Department's management. No approval will be granted if the request affects the delivery of covered services, access to providers, or quality of care for members.

B. MISREPRESENTATION OF INFORMATION

Misrepresentation of a Contractor's status, experience, or capability in the performance of this Contract may result in termination. Existence of known litigation or investigations in similar areas of endeavor may, at the discretion of the Department, result in immediate Contract termination and/or replacement.

C. MEETINGS

The Contractor shall participate in meetings with the Department of Medical Assistance Services, the MCOs, Quality Assurance Committees, or any other groups as necessary when requested to do so by the Department.

D. GOVERNING LAW

The Contract shall be governed and construed in accordance with the laws and regulations of the Commonwealth of Virginia.

E. INDEMNIFICATION

The Contractor hereby agrees to defend, hold harmless and indemnify the Department, its officers, agents and employees from any and all claims by third parties, regardless of their nature or validity, arising out of the performance of this Contract by the Contractor or its agents, employees, or subcontractors, including but not limited to any liability for costs and expenses, for violation of proprietary rights, copyrights, or rights of privacy arising out of the publication, translation, reproduction, delivery, performance, use or disposition of any data furnished under this Contract or based on any libelous or other unlawful matter contained in such data.

The Contractor is not required to defend, hold harmless or indemnify the Department, its officers, agents, and employees from claims resulting from services provided by an Agency of the Commonwealth of Virginia or its officers, agents, and employees when and if the Agency is expressly serving as a subcontractor under the provisions of this Contract.

F. INDEPENDENT CAPACITY

The Contractor and the agents and employees of the Contractor, in the performance of this Contract, shall act as independent Contractors and shall not act or represent themselves as officers, employees or agents of the Department or of the Commonwealth.

G. CONTRACTOR LIABILITY

The Contractor assumes full financial liability for developing and managing a health care delivery system that will arrange for or administer all FAMIS-covered services outlined in this Contract.

H. DRUG-FREE WORKPLACE

The Contractor shall acknowledge and certify that it understands that the following acts by the Contractor, its employees, and/or agents performing services on State property are prohibited from:

a. The unlawful manufacture, distribution, dispensing, possession or use of alcohol or other drugs; and

b. Any impairment or incapacitation from the use of alcohol or other drugs (except the use of drugs for legitimate medical purposes).

The Contractor shall further acknowledge and certify that it understands that a violation of these prohibitions constitutes a breach of contract and may result in default action being taken by the Commonwealth in addition to any criminal penalties that may result from such conduct.

I. UNIFORM ADMINISTRATIVE REQUIREMENTS

In accordance with 45 CFR § 74, the Contractor shall comply with all of the following Federal regulations.

1. Environmental Protection Rules

Each Contractor shall comply with all applicable standards, orders, or requirements issued under § 306 of the Clean Air Act (42 U.S.C. 7606, § 508 of the Clean Water Act [33 U.S.C. 1368]), which prohibits the use under nonexempt Federal contracts, grants, or loans of facilities included on the EPA List of Violating Facilities. The Contractor will

report violations to the applicable Federal agency and the U.S. EPA Assistant Administrator for Enforcement.

2. Copeland "Anti-Kickback" Act

Each Contractor shall comply with all applicable standards, orders, or requirements issued under 18 U.S.C. 874 and 40 U.S.C.276c, and as supplemented by Department of Labor regulations, 29 CFR part 3. The Contractor shall report all suspected or reported violations to the applicable Federal agency.

3. Davis-Bacon Act

Each Contractor shall comply with all applicable standards, orders, or requirements issued under 40 U.S.C. 276, and as supplemented by Department of Labor regulations, 29 CFR part 5. The Contractor shall report all suspected or reported violations to the applicable Federal agency.

4. Contract Work Hours and Safety Standards Act

Each Contractor shall comply with all applicable standards, orders, or requirements issued under 40 U.S.C 327-333, and as supplemented by Department of Labor regulations, 29 CFR part 5. The Contractor shall report all suspected or reported violations to the applicable Federal agency.

5. Rights to Inventions Made Under a Contract or Agreement

Contracts or agreements for the performance of experimental, developmental, or research work shall provide for the rights of the Federal Government and State of Virginia in any resulting invention in accordance with 37 CFR part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements," and any further implementing regulations issued by U.S. Department of Health and Human Services.

6. Byrd Anti-Lobbying Amendment

Each Contractor shall comply with all applicable standards, orders, or requirements issued under 31 U.S.C. 1352 and 45 CFR part 93. No appropriated funds may be expended by the recipient of a Federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered Federal actions: the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

7. Debarment and Suspension

Each Contractor shall comply with all applicable standards, orders, or requirements issued under Executive Orders 12549 and 12689, and 45 CFR part 76. Executive Order (E.O.) 12549 provides that, to the extent permitted by law, Executive departments and agencies shall participate in a government wide system for nonprocurement debarment and suspension. A person who is debarred or suspended shall be excluded from Federal financial and non-financial assistance and benefits under Federal programs and activities. Debarment or suspension of a participant in a program by one agency shall have government wide effect.

8. Energy Policy and Conservation Act

The Contractor shall comply with any mandatory standards and policies relating to energy efficiency which are contained in the State energy conservation plan issued in compliance with the Energy Policy and Conservation Act, Public Law 94-163.

J. INSURANCE

Before delivering services under this Contract, the Contractor shall obtain the proper insurance coverage during the term of the Contract, and ensure that all insurance coverages shall be provided by insurance companies authorized by the Virginia State Corporation Commission to sell insurance in the Commonwealth of Virginia. The Contractor shall have the following insurance coverages at the time the Contract is awarded and during the Contract duration and annually submit documentation verifying coverage to the Department:

1. Professional Liability Insurance for the Contractor's Medical Director

Insurance in the amount of at least one million dollars ($1,000,000) for each occurrence shall be maintained by the Contractor for the Medical Director.

2. Workers' Compensation

The Contractor shall obtain and maintain, for the duration of this Contract, workers' compensation insurance for all of its employees working in the Commonwealth of Virginia. In the event any work is subcontracted, the Contractor shall require its subcontractor(s) similarly to provide workers' compensation insurance for all the latter's employees working in the Commonwealth. Any subcontract executed with a firm not having the requisite workers' compensation coverage will be considered void by the Commonwealth of Virginia.

3. Employer's Liability

The Contractor shall maintain at least one hundred thousand dollars ($100,000) in liability coverage.

4. General Liability

The Contractor shall maintain no less than five hundred thousand dollars ($500,000) in combined single-limit liability coverage. The Commonwealth of Virginia is to be named as an additional insured with respect to the services to be procured. This coverage is to include Premises/Operations Liability, Products and Completed Operations Coverage, Independent Contractor's Liability, and Personal Injury Liability. DMAS acknowledges that the Contractor's coverage may be provided under blanket commercial general liability policies that insure the parent company and its subsidiaries.

5. Automobile Liability

The Contractor shall maintain five hundred thousand dollars ($500,000) per occurrence in automobile liability insurance for its corporate employees who use an automobile for business purposes.

K. TRANSITION

The Contractor shall provide for continuity of services, which is vital to the Department's overall effort to provide managed care services to its FAMIS population. Continuity of service, therefore, must be maintained at a consistently high level without interruption. Upon expiration or termination of this Contract, a successor (i.e., another contractor) must continue these services and may need transitional assistance, such as training, transferring records and encounter data, etc. The Contractor shall, therefore, be required to prepare a transition plan to provide phase-in, phase-out services and cooperate in an effort to positively effect an orderly and efficient transition to a successor.

L. OMISSIONS

In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

M. WAIVER

No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the items of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

N. SEVERABILITY

If any provision of this Contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to FAMIS enrollees and if the remainder of this Contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

O. HEADINGS

The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

P. ASSIGNABILITY

Except as allowed under subcontracting, the Contract is not assignable by the Contractor, either in whole or in part, without the prior written consent of the Department.

Q. RIGHT TO PUBLISH

The Department agrees to allow the Contractor to write on subjects associated with the work under this Contract and have such writing published, provided the Contractor receives prior written approval from the Department before publishing such writings.

R. CONVENANT AGAINST CONTINGENT FEES

The Contractor shall warrant that no person or selling agency has been employed or retained to solicit and secure the FAMIS Contract upon an agreement or understanding for commission, percentage, brokerage, or contingency, excepting bona fide employees or selling agents maintained by the Contractor for the purpose of securing the business. For breach or violation of this warranty, the Commonwealth of Virginia shall have the right to cancel the Contract without liability or in its discretion, to deduct from the contract price or to otherwise recover the full amount of such commission, percentage, brokerage, or contingency.

S. DELIVERY DATES FOR INFORMATION REQUIRED BY THE DEPARTMENT

When the last day for submission of any contractually required information or reports to the Department by the Contractor falls on a Saturday, Sunday or legal holiday, the information may be delivered on the next day that is not a Saturday, Sunday or legal holiday.

T. HIPAA DISCLAIMER

THE DEPARTMENT MAKES NO WARRANTY OR REPRESENTATION THAT COMPLIANCE BY THE CONTRACTOR WITH THIS AGREEMENT OR THE HIPAA REGULATIONS WILL BE ADEQUATE OR SATISFACTORY FOR THE CONTRACTOR'S OWN PURPOSES OR THAT ANY INFORMATION IN THE CONTRACTOR'S POSSESSION OR CONTROL, OR TRANSMITTED OR RECEIVED BY THE CONTRACTOR, IS OR WILL BE SECURE FROM UNAUTHORIZED USE OR DISCLOSURE, NOR SHALL THE DEPARTMENT BE LIABLE TO THE CONTRACTOR FOR ANY CLAIM, LOSS OR DAMAGE RELATED TO THE UNAUTHORIZED USE OR DISCLOSURE OF ANY INFORMATION RECEIVED BY THE CONTRACTOR FROM THE DEPARTMENT OR FROM ANY OTHER SOURCE. THE CONTRACTOR IS SOLELY RESPONSIBLE FOR ALL DECISIONS MADE BY THE CONTRACTOR REGARDING THE SAFEGUARDING OF PHI.

ATTACHMENTS

ATTACHMENT I-TPL Other Coverage Monthly Report

Health Plan	Enrollee Name	FAMIS ID #	Other Coverage ID #	Other Coverage Effective Date	Type of Other Coverage	Other Coverage Carrier Name	Other Coverage Contact Information

ATTACHMENT II - SUMMARY OF FAMIS COVERED SERVICES 2006

No cost sharing will be charged to American Indians and Alaska Natives

Service	FAMIS Covered	Network Cost Sharing & Benefit Limits <150%	>150%	Notes and Day Limitations
Inpatient Hospital Services	Yes	$15 per confinement	$25 per confinement	The MCO is required to cover inpatient stays in general acute care and rehabilitation hospitals for all enrollees up to 365 days per confinement in a semi-private room or intensive care unit for the care of illness, injury, or pregnancy (includes medically necessary ancillary services). The Contractor shall cover alternative treatment plan for a patient who would otherwise require more expensive services, including, but not limited to, long-term inpatient care. The Contractor must approve in advance the alternative treatment plan.
Outpatient Hospital Services	Yes	$2 per visit (waived if admitted)	$5 per visit (waived if admitted)	The MCO shall cover outpatient hospital services which are preventive, diagnostic, therapeutic, rehabilitative or palliative in nature that are furnished to outpatients, and are furnished by an institution that is licensed or formally approved as a hospital by an officially designated authority for State standard-setting. Observation bed services shall be covered when they are reasonable and necessary to evaluate a medical condition to determine appropriate level of treatment or non-routine observation for underlying medical complications. Outpatient services include emergency services, surgical services, diagnostic, and professional provider services. Facility charges are also covered.
Chiropractic Services	Yes	$2 (limited to $500 per calendar year)	$5 (limited to $500 per calendar year)	The MCO shall provide coverage of medically necessary spinal manipulation and outpatient chiropractic services rendered for the treatment of an illness or injury.

Service	FAMIS Covered	Network Cost Sharing & Benefit Limits <150%	>150%	Notes and Day Limitations
Clinic Services Outpatient physician visit in the office or hospital Primary care Specialty care Maternity services	Yes	$2	$5	The MCO shall cover clinic services that are defined as preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are provided to outpatients and are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. With the exception of nurse-midwife services, clinic services are furnished under the direction of a physician or a dentist. Renal dialysis clinic visits are also covered.
Court Ordered Services	No			The MCO is not required to cover this service unless the services is both medically necessary and is a FAMIS covered service.
Dental Services	No except in certain circumstances			The Contractor is required to cover CPT codes billed by an MD as a result of an accident. The Contractor is required to cover CPT and other "non-CDT" procedure codes billed for medically necessary procedures of the mouth for adults and children. The Contractor is required to cover medically necessary anesthesia and hospitalization services for certain individuals when determined such services are required to provide dental care.
Early, Periodic Screening, Diagnosis and Treatment (EPSDT)	No			The MCO is not required to cover this service.

Service	FAMIS Covered	Network Cost Sharing & Benefit Limits <150%	>150%	Notes and Day Limitations
Early Intervention Services	Yes	$2 per visit (limited to $5,000 per member per calendar year)	$5 per visit (limited to $5,000 per member per calendar year)	The MCO shall cover medically necessary FAMIS covered services for children from birth to age three who are determined eligible for Part C services of the Individuals with Disabilities Education Act by the Department of Mental Health, Mental Retardation and Substance Abuse Services or applicable Early Intervention Intragency Council. Services are covered up to $5,000 per enrollee per calendar year. All services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable. The MCO or its designated subcontractor may require prior authorization of services for the purposes of determining medical necessity of therapies and services.
Emergency Services using Prudent Layperson Standards for Access	Yes			The MCO shall provide for the reasonable reimbursement of services needed to ascertain whether an emergency exists in instances in which the clinical circumstances that existed at the time of the beneficiary's presentation to the emergency room indicate that an emergency may exist. The MCO shall ensure that all covered emergency services are available twenty-four (24) hours a day and seven (7) days a week.
Hospital emergency room		$2 per visit	$5 per visit	
Physician care		$2 per visit (waived if part of ER visit for true emergency)	$5 per visit (waived if part of ER visit for true emergency)	The MCO shall cover all emergency services provided by out-of-network providers. The MCO may not require prior authorization for emergency services. This applies to out-of-network as well as to in-network services that an enrollee seeks in an emergency.
Non-emergency use of the Emergency Room		$10 per visit	$25 per visit	Enrollees who present to the emergency room shall pay the emergency room co-payment. If it is determined that the visit was a non-emergency, the hospital may bill the enrollee only for the difference between the emergency room and non-emergency co-payments, i.e. $8.00 for <150% and $20.00 for >150%. The hospital may not bill for additional charges.

Service	FAMIS Covered	Network Cost Sharing & Benefit Limits <150% >150%		Notes and Day Limitations
Post Stabilization Care Following Emergency Services	Yes			The MCO must cover post-stabilization services subsequent to an emergency that a treating physician views as medically necessary AFTER an emergency medical condition has been stabilized. The MCO must cover the following services without requiring authorization, and regardless of whether the enrollee obtains the services within or outside the MCO's network.
Experimental and Investigational Procedures	No			The MCO is not required to cover this service.
Family Planning Services	Yes	$2 per visit	$5 per visit	The MCO shall cover all family planning services, which includes services and drugs and devices for individuals of childbearing age which delay or prevent pregnancy, but does not include services to treat infertility or to promote fertility. FAMIS covered services include drugs, and devices provided under the supervision of a physician. The MCO may not restrict an enrollee's choice of provider for family planning services or drugs and devices, and the MCO is required to cover all family planning services and supplies provided to its enrollees by network providers. *Code of Virginia* § 54.1-2969 (D), as amended, states that minors are deemed adults for the purpose of consenting to medical services required in case of birth control, pregnancy or family planning, except for purposes of sexual sterilization.

Service	FAMIS Covered	Network Cost Sharing & Benefit Limits <150%	>150%	Notes and Day Limitations
Hearing Aids	Yes	$2 limited to 2 every 5 years and $476 monoaural or $825 binaural	$5 limited to 2 every 5 years and $476 monoaural or $825 binaural	The MCO shall cover hearing aides as outlined under Durable Medical Equipment. Hearing aides shall be covered twice every five years.
Home Health Services	Yes	$2 per visit	$5 per visit	The MCO shall cover home health services, including nursing and personal care services, home health aide services, PT, OT, speech, hearing and inhalation therapy up to 90 visits per calendar year. Personal care means assistance with walking, taking a bath, dressing; giving medicine; teaching self-help skills; and performing a few essential housekeeping tasks. The MCO is not required to cover the following home health services: medical social services, services that would not be paid for by FAMIS if provided to an inpatient of a hospital, community food service delivery arrangements, domestic or housekeeping services which are unrelated to patient care, custodial care which is patient care that primarily requires protective services rather than definitive medical and skilled nursing care services, and services related to cosmetic surgery.
Hospice Services	Yes	$0	$0	The MCO shall cover hospice care services to include a program of home and inpatient care provided directly by or under the direction of a licensed hospice. Hospice care programs include palliative and supportive physician, psychological, psychosocial, and other health services to individuals utilizing a medically directed interdisciplinary team. Hospice care services must be prescribed by a Provider licensed to do so; furnished and billed by a licensed hospice; and medically necessary. Hospice care services are available if the enrollee is diagnosed with a terminal illness with a life expectancy of six months or fewer.

Service	FAMIS Covered	Network Cost Sharing & Benefit Limits <150%	>150%	Notes and Day Limitations
Immunizations	Yes	$0	$0	The MCO is required to cover immunizations. The MCO shall ensure that providers render immunizations, in accordance with the most current Advisory Committee on Immunization Practices (ACIP) or the American Academy of Pediatrics Advisory Committee Recommendations for children under age six (6). The MCO shall allow for an annual flu vaccine without limitations to age and without the requirement of meeting the CDC at risk guidelines. The MCO is required to work with the Department to achieve its goal related to increased immunization rates. The MCO is responsible for educating providers, parents and guardians of enrollees about immunization services, and coordinating information regarding enrollee immunizations. FAMIS eligible enrollees shall not qualify for the Free Vaccines for Children Program.
Inpatient Mental Health Services	Yes	$15 per confinement	$25 per confinement	Inpatient mental health services are covered for up to 30 days per calendar year, including partial day treatment services. Inpatient hospital services may include room, meals, general-nursing services, prescribed drugs, and emergency room services leading directly to admission. The MCO shall not cover any services rendered in free-standing psychiatric hospitals to enrollees up to nineteen (19) years of age. Medically necessary inpatient psychiatric services rendered in a psychiatric unit of a general acute care hospital shall be covered for all FAMIS enrollees within the limits of coverage prescribed in the FAMIS plan and State regulations. All inpatient mental health admission for individuals of any age to general acute care hospitals shall be approved by the MCO using its own prior authorization criteria. The MCO may cover services rendered in free-standing psychiatric hospitals as an enhanced benefit.

Service	FAMIS Covered	Network Cost Sharing & Benefit Limits <150%	>150%	Notes and Day Limitations
Inpatient Rehabilitation Hospitals	Yes	$15 per confinement	$25 per confinement	The MCO shall cover inpatient rehabilitation services in facilities certified as rehabilitation hospitals and which have been certified by the Department of Health.
Inpatient Substance Abuse Services	Yes	$15 per confinement	$25 per confinement	Inpatient substance abuse services in a substance abuse treatment facility are covered for up to 90 days per enrollee (maximum lifetime benefit).
Laboratory and X-ray Services	Yes	$2 per visit	$5 per visit	The MCO is required to cover all laboratory and x-ray services ordered, prescribed and directed or performed within the scope of the license of a practitioner in appropriate settings, including physician office, hospital, independent and clinical reference labs. No co-pay shall be charged for laboratory or x-ray services that are performed as part of an encounter with a physician.
Lead Testing	Yes	$0	$0	The MCO is required to cover blood lead testing as part of well baby, well childcare.
Mammograms	Yes	$0	$0	MCO is required to cover low-dose screening mammograms for determining presence of occult breast cancer
Medical Supplies Medical Equipment	Yes	$0 for supplies $2 per item for equipment	$0 for supplies $5 per item for equipment	The MCO shall cover durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices). Durable medical equipment and prosthetic devices and eyeglasses are covered when medically necessary. The Contractor is responsible for payment of any specially manufactured DME equipment that was prior authorized by the Contractor.

Service	FAMIS Covered	Network Cost Sharing & Benefit Limits <150%	>150%	Notes and Day Limitations
Medical Transportation	Yes	$2	$5	Professional ambulance services when medically necessary are covered when used locally or from a covered facility or provider office. This includes ambulance services for transportation between local hospitals when medically necessary; if prearranged by the Primary Care Physician and authorized by the MCO if, because of the enrollee's medical condition, the enrollee cannot ride safely in a car when going to the provider's office or to the outpatient department of the hospital. Ambulance services will be covered if the enrollee's condition suddenly becomes worse and must go to a local hospital's emergency room. For coverage of ambulance services, the trip to the facility or office must be to the nearest one recognized by the MCO as having services adequate to treat the enrollee's condition; the services received in that facility or provider's office must be covered services; and if the MCO or the Department requests it, the attending provider must explain why the enrollee could not have been transported in a private car or by any other less expensive means. Transportation services are not provided for routine access to and from providers of covered medical services.
Organ Transplantation	Yes	$15 per confinement and $2 per outpatient visit (Services to identify donor limited to $25,000 per member)	$25 per confinement and $5 per outpatient visit (Services to identify donor limited to $25,000 per member)	The MCO shall cover organ transplantation services as medically necessary for all eligible individuals, to include transplants of tissues, autologous, allogeneic or synegenic bone marrow transplants or other forms of stem cell rescue for children with lymphoma and myeloma. The MCO shall cover kidney transplants for patients with dialysis dependent kidney failure, heart, liver, pancreas, and single lung transplants. The MCO is not required to cover transplant procedures determined to be experimental or investigational.

Service	FAMIS Covered	Network Cost Sharing & Benefit Limits <150%	>150%	Notes and Day Limitations
Outpatient Mental Health and Substance Abuse Services	Yes	$2 per visit	$5 per visit	The MCO is responsible for covering outpatient mental health and substance abuse clinic services. Psychiatric and substance abuse services are limited to no more than a combined total of 50 medically necessary visits for treatment with a licensed mental health or substance abuse professional each calendar year. Inpatient and outpatient services may include diagnostic services; mental health services including: detoxification, individual psychotherapy, group psychotherapy psychological testing, counseling with family members to assist in the patient's treatment and electroconvulsive therapy.
Community Mental Health Rehabilitative Services – Community Mental Health and Community Mental Retardation Services **(Effective 08/01/03)**	Yes			The MCO is not required to cover community mental health rehabilitative services. The Department will reimburse these services. The MCO must provide information and referrals as appropriate to assist enrollees in accessing these services. The MCO is required to cover prescription drugs prescribed by the outpatient mental health provider. The MCO is not required to cover transportation to or from these services.
Pap Smears	Yes	$0	$0	The MCO is required to cover annual pap smears
Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services	Yes	$2 per visit	$5 per visit	The MCO shall cover therapy services that are medically necessary to treat or promote recovery from an illness or injury, to include physical therapy, speech therapy, occupational therapy, inhalation therapy, and intravenous therapy. The MCO shall not be required to cover those services rendered by a school health clinic.

Service	FAMIS Covered	Network Cost Sharing & Benefit Limits <150%	>150%	Notes and Day Limitations
Physician Services Inpatient physician care Outpatient physician visit in the office or hospital Primary care Specialty care Maternity services	Yes	 $0 $2 per visit $2 per visit $2 per visit	 $0 $5 per visit $5 per visit $5 per visit	The MCO shall cover all symptomatic visits provided by physicians or physician extenders within the scope of their licenses. Cosmetic services are not covered unless performed for medically necessary physiological reasons. Physician services include services while admitted in the hospital, outpatient hospital departments, in a clinic setting, or in a physician's office.
Pregnancy-Related Services	Yes	$2 per visit	$5 per visit	The MCO shall cover services to pregnant women, including prenatal services. For prenatal services, the co-pay applies to the first visit only. **No cost sharing will be charged to recipients enrolled in FAMIS MOMS.**

Service	FAMIS Covered	Network Cost Sharing & Benefit Limits <150%	>150%	Notes and Day Limitations
Prescription Drugs Retail up to 34-day supply Retail 35-90-day supply Mail service up to 90-day supply (If a generic is available, enrollee pays the copayment **plus** 100% of the difference between the allowable charge of the generic drug and the brand drug.)	Yes	 $2 per prescription $4 per prescription $4 per prescription	 $5 per prescription $10 per prescription $10 per prescription	The MCO shall be responsible for covering all medically necessary drugs for its enrollees that by Federal or State law requires a prescription. The MCO shall cover all FAMIS covered prescription drugs prescribed by providers licensed and/or certified as having authority to prescribe the drug. The MCO is required to cover prescription drugs prescribed by the outpatient mental health provider. The MCO is not required to cover Drug Efficacy Study Implementation (DESI) drugs or over the counter prescriptions. The MCO may establish a formulary, may require prior authorization on certain medications, and may implement a mandatory generic substitution program. However, the MCO shall have in place special authorization procedures to allow providers to access drugs outside of this formulary, if medically necessary. The MCO shall establish policies and procedures to allow providers to request a brand name drug for an enrollee if it is medically necessary. The MCO shall cover atypical antipsychotic medications developed for the treatment of schizophrenia. The MCO shall ensure appropriate access to the most effective means to treat, except where indicated for the safety of the patient. The Contractor shall not cover prescriptions for erectile dysfunction medication.
Private Duty Nursing Services	Yes	$2 per visit	$5 per visit	The MCO shall cover private duty nursing services only if the services are provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN); must be medically necessary; the nurse may not be a relative or member of the enrollee's family; the enrollee's provider must explain why the services are required; and the enrollee's provider must describe the medically skilled service provided. Private duty nursing services must be pre-authorized.

Service	FAMIS Covered	Network Cost Sharing & Benefit Limits <150%	>150%	Notes and Day Limitations
Prosthetics/Orthotics	Yes	$2 per item	$5 per item	The MCO shall cover prosthetic services and devices (at minimum, artificial arms, legs and their necessary supportive attachments) for all enrollees. At a minimum, the MCO shall cover medically necessary orthotics (i.e., braces, splints, ankle, foot orthoses, etc. add items listed in Handbook) for enrollees. The MCO shall cover medically necessary orthotics for enrollees when recommended as part of an approved intensive rehabilitation program.
School Health Services	Yes			The MCO is not required to cover school health services for special education students that include physical therapy, occupational therapy, speech language pathology, and skilled nursing services. The Department will reimburse these services.
Second Opinions	Yes	$2 per visit	$5 per visit	The MCO shall provide coverage for second opinions when requested by the enrollee for the purpose of diagnosing an illness and/or confirming a treatment pattern of care. The MCO must provide for second opinions from a qualified health care professional within the network, or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee. The MCO may require an authorization to receive specialty care for an appropriate provider; however, cannot deny a second opinion request as a non-covered service.
Skilled Nursing Facility Care	Yes	$15 per confinement	$25 per confinement	The MCO shall cover medically necessary services that are provided in a skilled nursing facility for up to 180 days per confinement.
Telemedicine Services	Yes			The MCO shall provide coverage for telemedicine services at least to the extent covered by the Department. Telemedicine is defined as the real time or near real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment. Currently the Department recognizes only physicians and nurse practitioners for medical telemedicine services and requires one of these types of providers at the main (hub) satellite (spoke) sites for a telemedicine service to be reimbursed. Additionally, the Department currently recognizes three telemedicine projects.

Service	FAMIS Covered	Network Cost Sharing & Benefit Limits <150% >150%		Notes and Day Limitations
Temporary Detention Orders	No			The MCO is not required to cover this service.
Therapy Services	Yes	$15 per confinement if inpatient $2 per visit outpatient	$25 per confinement if inpatient $5 per visit outpatient	The MCO shall cover the costs of renal dialysis, chemotherapy and radiation therapy, and intravenous and inhalation therapy.
Transportation	No			Transportation services are not provided for routine access to and from providers of covered medical services.
Well Baby and Well Child Care	Yes	$0	$0	The Contractor shall cover routine well baby and well childcare including routine office visits with health assessments and physical exams, as well as routine lab work and age appropriate immunizations. The following services rendered for the routine care of a well child: Laboratory services: blood lead testing, HGB, HCT or FEP (maximum of 2, any combination); Tuberculin test (maximum of 3 covered); Urinalysis (maximum of 2 covered); Pure tone audiogram for age 3-5 (maximum of 1); Machine vision test (maximum of 1 covered). Well child visits rendered at home, office and other outpatient provider locations are covered at birth and months 1, 2, 4, 6, 9, 12, 15, 18 and covered at ages 2, 3, 4, 5, 6, 8, 10, 12, 14, 16, 18. Hearing Services: All newborn infants will be given a hearing screening before discharge from the hospital after birth.

Service	FAMIS Covered	Network Cost Sharing & Benefit Limits <150% >150%		Notes and Day Limitations
Vision Services Once every 24 Routine eye exam Eyeglass frames (one pair) Eyeglass lenses (one pair) single vision bifocal trifocal contacts	Yes	 $2 Member o-payment Reimburseme by Plan: $25 $35 $50 $88.50 $100	 $5 Member payment Reimbursem by Plan: $25 $35 $50 $88.50 $100	The MCO shall cover vision services that are defined as diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians. Routine refractions shall be allowed at least once in twenty-four (24) months. Routine eye examinations, for all enrollees, shall be allowed at least once every two- (2) years. The MCO shall cover eyeglasses (one pair of frames and one pair of lenses) or contact lenses prescribed as medically necessary by a physician skilled in diseases of the eye or by an optometrist for enrollees.
Inpatient Mental Health Services Rendered in a Freestanding Psychiatric Hospital	No			The MCO is not required to cover this service. However, the MCO may cover services rendered in free-standing psychiatric hospitals to enrollees up to nineteen (19) years of age as an enhanced benefit offered by the MCO. Medically necessary inpatient psychiatric services rendered in a psychiatric unit of a general acute care hospital shall be covered for all FAMIS enrollees within the limits of coverage prescribed in the FAMIS plan and State regulations.

Service	FAMIS Covered	Network Cost Sharing & Benefit Limits <150%	>150%	Notes and Day Limitations
Abortions	Yes			The Department will be responsible for payment of abortion services meeting Federal Medicaid requirements under the fee-for-service program.
Cost Sharing:				
Annual Co-Payment Limit		Calendar year limit: $180 per family	Calendar year limit: $350 per family	Plan pays 100% of allowable charge once limit is met for covered services. No cost sharing will be charged to American Indians and Alaska Natives.
FAMIS MOMS				Benefits are the same as those available under Medallion II. **No cost sharing will be charged to recipients enrolled in FAMIS MOMS.**

ATTACHMENT III
MCO ACTIVE PROVIDER FILE DATA REQUIREMENTS

FIELD NAME	DATA VARIATIONS / EXAMPLES
MCO Code*	Your number assigned by DMAS
Provider Type*	Examples are: Ancillary, CSB (Community Service Board), Early Intervention, Health Department, Hospital, Independent Lab, OB/GYN, Optical, PCP, PCP-Pediatric, Pharmacy, Psychiatric
Provider Specialty*	Examples are: Anesthesiologist, Cardiologist, DME, Home Health, Hospital, Infectious Disease, Internal Medicine, OB/GYN, Optometrist, Orthodontist, Pediatrician, Transportation, Urgent Care, etc.
NPI/API	9999999999
PCP Status*	Y or N
Provider Last Name*	Smith or ABC Hospital
Provider First Name	Robert or blank if facility name listed above
Address line 1*	123 Any Road
Address line 2	Suite 900
City*	Anywhere
Zip code*	99999
+4	9999
Phone area code	999
Phone number	999-9999
Phone extension	9999
24 Hour Access*	Y or N
Other Language Spoken 1	Spanish
Other Language Spoken 2	Russian
PCP maximum panel size**	2,500
PCP assigned panel size**	150
PCP limitations/restrictions**	Children Age 5-18, or No new patients
Tax ID*	999999999

* This field must be included for every record in the file. ** This field must be included for every PCP record in the file. Notes: The quarterly report to DMAS must be reported in an excel spreadsheet and must be provided subcontractor network cannot just list the subcontractor name, but must include the vendors they contract with to provide services to the FAMIS enrollees.
The entire network should be in one file, formatted as above, not separate files or separate worksheets within one file. For providers with multiple office locations, each office location must be on a different line, via diskette or may be e-mailed to the MCO Compliance Analyst.

The complete provider file; i.e., all PCPs, specialists, and subcontractors (this includes transportation, psychiatric, optical, and/or pharmacy, etc.) must be submitted.

ATTACHMENT III (a)

Required Fields for Provider File Submission for the Enrollment Broker

The format of the enrollment broker provider file is not mandated, The following fields are required fields for any file submitted, however.

Number	Data Element	Type	Size	Start	Stop
1	MCO Code*	numeric	10	1	10
2	Action Ind* (A=Active, D=Delete)	alpha	1	11	11
3	Clinic/PCP Ind* (P=PCP, C=Clinic)	alpha	1	12	12
4	Provider Number **	alpha	15	13	27
5	Program Code* (M2=Medallion II)	alpha	2	28	29
6	Provider Last Name*	alpha	30	30	59
7	Provider First Name*	alpha	30	60	89
8	Address Line 1	alpha	30	90	119
9	Address Line 2	alpha	30	120	149
10	City	alpha	30	150	179
11	Zip Code	numeric	9	180	188
12	Phone Area Code	numeric	3	189	191
13	Phone Number	numeric	7	192	198
14	Phone Extension	numeric	4	199	202
15	Office Hours	alpha	25	203	227
16	Specialty Code (see below)	alpha	1	228	228
17	Language 1 (see below)	alpha	2	229	230
18	Language 2	alpha	2	231	232
19	Language 3	alpha	2	233	234
20	Language 4	alpha	2	235	236
21	Language 5	alpha	2	237	238

* This filed must be included for every record in the file

** The Provider Number field must be unique per provider and office location

Specialty Codes

C=Clinic
F=Family
G=General
I=Internist
O=OB/GYN
P=Pediatrics
X=Other

Languages

SP=Spanish
GR=German
FR=French
IT=Italian
RS=Russian

ATTACHMENT IV
NETWORK PROVIDER AGREEMENT

A. RIGHT OF DEPARTMENT TO APPROVE, MODIFY OR DISAPPROVE NETWORK PROVIDER AGREEMENTS

The Department may approve, modify and approve, or deny network provider agreements under this Contract at its sole discretion. The Department may, at its sole discretion impose such conditions or limitations on its approval of an agreement as it deems appropriate. The Department may consider such factors as it deems appropriate to protect the interests of the Commonwealth and enrollees, including but not limited to the proposed provider's past performance. The Contractor shall submit any new network provider agreement at least thirty (30) days prior to the effective date for review, and annually thereafter. Revisions to any agreements must be submitted at least thirty (30) days prior to the effective date of use. The Contractor shall have no greater than one hundred and twenty (120) days to implement a change that requires the Contractor to find a new network provider, and sixty (60) days to implement any other change required by the Department, except that this requirement may be shortened by the Department if the health and safety of enrollees is endangered by continuation of an existing agreement. The Department will approve or disapprove an agreement within thirty (30) days after its receipt from the Contractor. The Department may extend this period by providing written notification to the Contractor if in the Department's sole opinion additional review or clarification is needed. Network provider agreements shall be deemed approved if the Department fails to provide notice of extension or disapproval within thirty (30) days.

The Department will review each type of agreement for services before contract signing. The Contractor shall initially submit each type of agreement for services with this Contract in the Attachments. The Department's review of the agreements will ensure that the Contractor has inserted the following standard language in all network provider agreements (except for specific provisions that are inapplicable in a specific Contractor management subcontract):

(Contractor's name) (Hereafter referred to as "Contractor") and its intended Network Provider, (Insert Network Provider's Name) (hereafter referred to as "Provider"), agree to abide by all applicable provisions of the Contract (hereafter referred to as FAMIS contract) with the Department of Medical Assistance Services. Provider compliance with the FAMIS contract specifically includes but is not limited to the following requirements:

1. No terms of this agreement are valid which terminate legal liability of the Contractor in the FAMIS Contract.

2. Provider agrees to participate in and contribute required data to Contractor's quality improvement and other assurance programs as required in the FAMIS contract.

3. Provider agrees to abide by the terms of the FAMIS contract for the timely provision of emergency and urgent care. Where applicable, the Provider agrees to follow those

procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency department Memorandums of Understanding signed by the Contractor in accordance with the FAMIS contract.

4. The Provider agrees to submit Contractor utilization data in the format specified by the Contractor, so the Contractor can meet the Department specifications required by FAMIS contract.

5. The Provider agrees to comply with all non-discrimination requirements in FAMIS contract.

6. The Provider agrees to comply with all record retention requirements and, where applicable, the special reporting requirements on sterilizations and hysterectomies stipulated in FAMIS contract.

7. The Provider agrees to provide representatives of Contractor, as well as duly authorized agents or representatives of the Department, the U.S. Department of Health and Human Services, and the State Fraud Unit access to its premises and its contract and/or medical records in accordance with FAMIS contract. Provider agrees otherwise to preserve the full confidentiality of medical records in accordance with FAMIS contract.

8. The Provider agrees to the requirements for maintenance and transfer of medical records stipulated in FAMIS contract. Provider agrees to make medical records available to enrollees and their authorized representatives within ten (10) working days of the record request.

9. The Provider agrees to ensure confidentiality of family planning services in accordance with FAMIS contract, except to the extent required by law, including, but not limited to, the Virginia Freedom of Information Act.

10. The Provider agrees not to create barriers to access to care by imposing requirements on enrollees that are inconsistent with the provision of medically necessary and covered FAMIS services.

11. The Provider agrees to clearly specify referral approval requirements to its providers and in any sub-subcontracts.

12. The Provider agrees not to bill a FAMIS enrollee for medically necessary services covered under the FAMIS contract and provided during the enrollee's period of Contractor enrollment. This provision shall continue to be in effect even if the Contractor becomes insolvent. However, if an enrollee agrees in advance of receiving the service and in writing to pay for a non-FAMIS covered service, then the Contractor, Contractor provider, or Contractor subcontractor can bill.

13. The Provider must forward to the Contractor medical records, within ten (10) working days of the Contractor's request.

14. The Providers shall promptly provide or arrange for the provision of all services required under the provider agreement. This provision shall continue to be in effect

for subcontract periods for which payment has been made even if the provider becomes insolvent until such time as the enrollees are withdrawn from assignment to the provider.

15. Except in the case of death or illness, the Provider agrees to notify the Contractor at least thirty (30) days in advance of disenrollment and agrees to continue care for his or her panel enrollees for up to thirty (30) day after such notification, until another PCP is chosen or assigned.

16. The Provider agrees to act as a PCP for a predetermined number of enrollees, not to exceed the panel size limits set forth in Article II of this Contract, to be stated in the network provider agreement.

17. The Contractor agrees to pay the Provider within thirty (30) days of the receipt of a claim for covered services rendered to a covered enrollee unless there is a signed agreement with the Provider that states another timeframe for payment that is acceptable to that Provider.

18. Notwithstanding any other provision to the contrary, the obligations of Virginia shall be limited to annual appropriations by its governing body for the purposes of the subcontract.

B. NETWORK PROVIDER AGREEMENT SUPPLEMENT

The Department recognizes that the Contractor may use a Provider Manual as a supplement to the Provider Agreement. Under that condition, it must be understood that the Contract takes precedence over any language in the Provider manual. The Contract must reference the Provider Manual and identify it as part of the Provider Agreement. The Manual must contain language that states the Manual, revisions, and amendments to it are part of the Provider Agreement.

C. REVIEW AND APPROVAL OF NEW PROVIDER AGREEMENTS AND IN APPROVED SUBCONTRACTS DURING THE CONTRACT PERIOD

New agreements and changes in approved agreements shall be reviewed and approved by the Department before taking effect. Agreements will be considered approved if the Department has not responded within thirty (30) consecutive days of the date of Departmental receipt of request.

1. This review requirement applies to changes that affect the amount, duration, scope, location, or quality of services. In other words, technical changes do not have to be approved.
2. Changes in rates paid to subcontractors do not have to be approved. However, changes in method of payment (e.g., fee-for-service, capitation) must be approved by the Department.
3. The Contractor shall submit to the Department within thirty (30) days of the end of the quarter, addition or deletion of agreements involving: a clinic or group of physicians, an individual physician or facility.

4. Subcontracts with State Agencies or political subdivisions shall be excluded from the requirements of this addendum to the extent excluded elsewhere in this Contract.

ATTACHMENT V

MCO INQUIRIES, GRIEVANCES / COMPLAINTS, AND APPEALS MONTHLY SUMMARY REPORT

THIS MONTH			
		Number	**Per 1000**
INQUIRIES			
TOTAL:			
SOURCE:	**Members**		
	Providers		
GRIEVANCES / COMPLAINTS			
TOTAL:			
SOURCE:	**Members**		
	Providers		
TYPE:	**Access**		
	Utilization/Medical Management		
	Provider Care and Treatment		
	Payment and Reimbursement		
	Administrative		
STATUS:	**Received**		
	Resolved		
	Outstanding		
APPEALS			
TOTAL:			
SOURCE:			
TYPE:	**Access**		
	Utilization/Medical Management		
	Provider Care and Treatment		
	Payment and Reimbursement		
	Administrative **Service Denied** **Reason**		
STATUS:	**Received**		
	Resolved		
	Outstanding		

The Contractor shall have in place appropriate administrative, technical, and physical safeguards to ensure the security and confidentiality of records.

Contractor shall submit all reports through electronic format (CD, diskette, etc.)

Reports	Contract Location	Time Frame
HEDIS Information	Art. II, K.	Annually
Adolescent Well-Care Visit	Art. II, K.	Annually
Childhood Immunization Status	Art. II, K.	Annually
Adolescent Immunization Status	Art. II, K.	Annually
Well-Child Visits in the First 15 Months of Life	Art. II, K.	Annually
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	Art. II, K.	Annually
Asthma Management Quality Study	Art. II, K.	Annually
Enrollee Info. Packet:	Art. II, D., 15.	Annually
Introduction Letter	Art. II, D., 15., a.	Annually
Sample FAMIS ID Card	Art. II, D., 15., b.	Annually
Provider Directory	Art. II, D., 15., c.	Annually
EOC/Handbook	Art. II, D., 15., d., e.	Annually
Updates to EOC, with cover letter explicitly identifying sections that have changed	Art. II, D., 16.	Annually, as needed 30 days prior to planned use
Percent of two year olds who have received each immunization specified by ACIP standards	Art. II, G., 28.	Annually
Quality Improvement Program	Art. II, K.	Annually
Mechanism for reporting serious quality resulting in suspension or termination of practitioner's license to the appropriate authorities	Art. II, K., 5.	(Annually) Defined in QIP Plan
Results of Internal Quality Studies	Art. II, K., 1.	Annually and upon request
Prior Year's Outcomes (QIP)	Art. II, K.	Annually
Utilization Management Plan	Art. II, K., 4.	Annually and upon revision
Physician Incentive Plan (PIP)	Art. II, J., 7.	Annually
Audit by Independent Auditor	Art. II, T.	Annually, within 30 calendar days of audit completion
All enrollment, disenrollment and educational documents and materials made available to FAMIS enrollees	Art. II, F.	Annually
GAAP Accounting System	Art. II, A., 5.	Duration of Contract
License issued by State Corporation Commission	Art. II, A., 1.	(Annually) Retain at all times. BOI issues annually
Network Provider Agreements	Attachment IV	(Annually) & 30 days prior to effective date
Vision	Attachment IV	(Annually) & 30 days prior to effective date
Hospital	Attachment IV	(Annually) & 30 days prior to effective date
Specialist	Attachment IV	(Annually) & 30 days prior to effective date
Pharmacy	Attachment IV	(Annually) & 30 days prior to effective date

Reports	Contract Location	Time Frame
Diagnostic/Lab	Attachment IV	(Annually) & 30 days prior to effective date
Physician (PCP)	Attachment IV	(Annually) & 30 days prior to effective date
Mental Health and Substance Abuse	Attachment IV	(Annually) & 30 days prior to effective date
Organizational Chart that outlines FAMIS Operational Division	Art. II, O.	Annually
Updated company background including awards, major changes, sanctions, etc.	Art. II, O.	Annually
Updated subcontractor company background including awards, major changes, sanctions, etc.	Art. II, O.	Annually
Written policies and procedures for the credentialing process that matches the credentialing and recredentialing standards from NCQA	Art. II, K., 5.	Annually
Written procedure for release of medical record information and obtaining consent for treatment	Art. II, L.	(Annually)
Program Integrity Plan (PIP) Policies and procedures for ensuring protection against actual or potential fraud and abuse	Art. II, Q.	Annually
Procedures for enrollee transition to new PCP	Art. II, D, 14.	Prior to signing initial contract and upon DMAS request
Written policies and procedures related to provider disenrollment	Art. II, J., 5., a.	Annually
Insurance Coverage	Art. XI, J	Annually
Policy and procedures for notifying PCPs of Panel Composition	Art. II, D., 12	Prior to signing initial contract and upon DMAS request
Policy and procedures for In and Out-of Network providers to verify member enrollment	Art. II, D., 13.	Annually, 5 business days of the date on which MCO receives enrollment report
Written Policies and Procedures which describe the informal and formal grievance and appeals process and how it operates	Art. II, P., 1., a.	Annually, Prior to implementation
Written policies and procedures and internal mechanisms for the prevention, detection and reporting of incidents of potential fraud and abuse by enrollees, by network providers, by subcontractors, and by the Contractor	Art. II, Q.	Annually
Written policy and procedure for maintaining the confidentially of data, including medical records and enrollee information and appointment records for treatment of sexually transmitted diseases	Art. IX, B.	Annually
If Physician Incentive Plan found to be potentially cost avoidance by limiting referrals	Art. II, J., 7.	(Annually) Contractor must demonstrate that all medically necessary referrals were authorized
Subcontractors for administrative services	Art. II, B.	(Annually) and 30 calendar days prior to effective date
Lab	Art. II, B.	(Annually) and 30 calendar days prior to effective date
Vision	Art. II, B.	(Annually) and 30 calendar days prior to effective date

Reports	Contract Location	Time Frame
Pharmacy	Art. II, B.	(Annually) and 30 calendar days prior to effective date
Mental Health	Art. II, B.	(Annually) and 30 calendar days prior to effective date
After Hours Nurse Line	Art. II, B.	(Annually) and 30 calendar days prior to effective date
Enhanced Services	Art. II, G, 41.	Annually and 30 calendar days prior to implementing or providing
Written policies and procedures for providing medically necessary in-plan services when ordered by a non-network dentist.	Art. II. J	Annually
Physician Incentive Plan (PIP)	Article II, J, 7.	Annually
Live Birth Outcomes Report	Art. II, D., 4.	Monthly
Provider file to DMAS	Art. II, I., 1., d.	Quarterly
BOI Financial Reports and any revisions	Art. II, A., 4, a.	Quarterly - due same day sent to BOI (MCO must file within 45 days from end of quarter)
Submit any addition or deletion of agreements involving: a clinic or group of physicians, an individual physician or facility	Attachment IV	Quarterly (within 30 days of the end of a quarter)
Returned ID Card List	Art. II, E., 2.	Monthly
Date and number of ID cards mailed to new enrollees, each month	Art. II, E., 2.	Monthly, within 48 hours of completion of monthly mailing
Number of ID cards re-issued during the prior month	Art. II, E., 2.	Monthly, by the 5th of each month
Electronic provider file to CPU	Art. II, I., 1., d.	Monthly
Provider ASA and Abondonment Rates	Art. II.J	Monthly
Report Sentinel Events	Art. II, O.	Monthly
Summary of inquires, complaints, grievances, and appeals	Art. II, P., 3.	Monthly on the 15th
Complaint/Grievance Log	Art. II, P., 3.	Monthly on the 15th
Appeal Log	Art. II, P., 3.	Monthly on the 15th
Provider network changes regarding termination, pending termination, or pending modification in the subcontractor's or network provider terms and not otherwise addressed in Attachment IV, for FAMIS	Art. II, J.	30 business days
Changes or modifications to policies and procedures for assigning enrollees to a PCP	Art. II, D., 14	30 calendar days prior to implementation
Changes to hospital contracts (if change impacts scope of covered services, number of individuals covered and/or units of service covered)	Art. II, I., 6.	15 calendar days
Changes to key staff positions (lost and/or added)	Art. II, A., 9.	Within 15 days of any change
Program or Site Change	Art. II, D., 17, k.	14 calendar days prior to implementation
Any enrollee discovered to have comprehensive health coverage	Art. IV, D., 1.	Monthly
Any enrollee discovered to have workers' compensation coverage	Art. IV, D., 2.	Monthly
Any enrollee identified as having trauma injuries	Art. IV, H., 3.	Monthly

Reports	Contract Location	Time Frame
Changes to/terminations of network provider agreements that could impact access to care	Art. II, I., 1., b.	Within 7 days of change/termination
Change in Ownership	Art. II, A., 8.	5 calendar days prior to change
Prior Authorized Services Information for enrollees	Art. II, O	Within 5 days upon request
Sanctions or changes in reserve requirements imposed by BOI or any other entity	Art. II, A., 7.	2 business days
Copy of grievance or appeal, along with a copy of the notice that was sent to the enrollee	Art. II, P., 1., c.	Within 2 days of receipt
Copy of final grievance or appeal decision	Art. II, P., 1., d.	Within 48 hours of receipt of the complaint
Report incidents of potential or actual fraud and abuse (of the Contractor, its network providers, or its enrollees)	Art. II, Q., 4.	Within 48 hours of initiation of any investigative action or within 48 hours of notification that another entity is conducting such an investigation
Report incidents of potential or actual marketing services fraud and abuse	Art. II, Q., 4.	Immediately (within 48 hours of discovery of the incident)
Disclosure and justification of transactions between the Contractor and any Party of Interest	Art. II, A., 8.	At least 5 days prior to any change in ownership
Disclosure of all entities with which a FAMIS provider has an ownership or control relationship	Art. II, A., 8.	At least 5 days prior to any change in ownership
System to monitor provider network to ensure access standards are met	Art. II, I., 12.	Be prepared to demonstrate that these access standards have been met
Review the Contractor's policies and procedures and determine conditions for formal notification of situations involving quality of care	Art. II, K., 7.	Department reserves the right
All new and/or revised marketing and information materials	Art. II, C., 1., c.	Prior to their planned distribution
Subcontractors to submit for review and approval, all mass-generated letters intended for provider and/or enrollee distribution	Art. II, B.	Prior to their planned distribution
Copy of all oral, written or electronic reports, presentations or other materials, in any form, whatsoever based, in whole or in part, on the Data must be reviewed and approved by DMAS	Attachment IX	Prior to their planned distribution
Changes in the Basis of Accounting used	Art. II, A., 5.	Prior to Change
Changes to enrollee complaint, grievance, appeal procedures	Art. II, P., 1., a.	Prior to implementation
Create a Data Security Plan	Art. IX. C.	Work with Internal Audit
FAMIS Third Party Liability Information	Article II, O.	Monthly
FAMIS Out-of-Pocket Maximum Payments	Article II, O.	Monthly
FAMIS Newborn Report	Article II, O.	Monthly
FAMIS Enrollee Address Change Report	Article II, O.	Monthly
Data Certification	Article II Q	Monthly (Encounters) Weekly (All other data)
Listing of Providers who Have Failed Accreditation/Credentialing	Article V	Quarterly
Hospital Inpatients Days Report	Article X, A.	Annually
Year to Date Co-payment Amount	Article II.O	As needed
Enhanced Services – inform the Department prior to implementing any new enhanced services	Article II, G., 41.	Annually and 30 calendar days prior to implementing any new enhanced

Reports	Contract Location	Time Frame
		services
Incarcerated Enrollee Report	Article II, G.	Monthly
Abuse, Corrective Action Overpayment/Recovery Report	Article II.Q	Quarterly
Clinical Practice Guidelines	Article II.K	Prior to signing initial contract and upon DMAS request
Policies and procedures for providing medically necessary in-plan services when ordered by a non-network dentist.	Article II, I	Annually
Provider Satisfaction Survey	Article II, J	Bi -annually
Certification by State Health Commissioner (MCHIP – Department of Health)	Article II, A., 3.	(Annually) Change & Repl	Art. II, A., 3.
FAMIS MOMS • *Frequency of Ongoing Prenatal Care* • *Discharge and Average Length of Stay Maternity Care* • *C-section Rate* • *Vaginal Birth After C-section (VBAC) Occurence* • *Postpartum Care Rates*	*Article II.O*	*Annually*

ATTACHMENT VII
HOSPITAL INPATIENT DAYS REPORT FORM

Hospital Name _____

City and State _____

		Total Days of Stay	Number of Discharges	Total Charges	Total Payments
1.	Pediatrics				
2.	Nursery including Preemie and Sick Baby Days				
3.	Neonatal Intensive Care				
4.	Psychiatric				
5.	Rehabilitation				
6.	Denied Days				

Note: This Section must be completed for each hospital that received payment from the MCO during the contract period.

ATTACHMENT VIII - LIVE BIRTH OUTCOMES REPORT

MCO Name	Mother's Last Name	Mother's First Name	Mother's FAMIS Number	Mother's Effective Date in Plan	Mother's SSN or other ID Number	Mother enrolled in MCO prenatal program?	Newborn's DOB	Newborn's Birth Weight (in grams)	Estimated Gestation Period (in weeks)

ATTACHMENT IX
CONFIDENTIALITY AGREEMENT FORM

This Agreement between the Virginia Department of Medical Assistance Services (DMAS) and _____ (Contractor) sets forth the terms and conditions for the disclosure of information concerning FAMIS applicants, enrollees or providers (Data). For purposes of this Agreement, the Contractor includes any individual, entity, corporation, partnership, or otherwise, with or without a contractual agreement with DMAS, who has been granted permission by DMAS to use or to access Data in DMAS' possession.

Following execution of any contract with DMAS, the selected Contractor shall submit a written Security Plan, addressed to the DMAS Director of Internal Audit & Contract Evaluation, describing the manner in which the Contractor will use DMAS Data and the procedures the Contractor will employ to secure that Data. The HIPAA Office of Privacy and Security will work with the Contractor in the preparation of the Security Plan. The uses of DMAS Data detailed in the Security Plan shall not be in violation of purposes directly related to State Plan administration included in 42 C.F.R. § 431.302. The Contractor's Security Plan shall be eventually incorporated as Attachment 1 to this Agreement. No other uses of DMAS Data outside of the purposes stated in Attachment 1 will be allowed. The Contractor agrees to restrict the release of information to the minimum information necessary to serve the stated purpose described in the Security Plan. The Contractor agrees that there will be no commercial use of the DMAS data which he receives or creates in fulfillment of his contractual obligations.

The Contractor agrees to fully comply with all federal and state laws and regulations, especially 42 C.F.R. 431, Subpart F, and the *Code of Virginia*, Title 2.1, Chapter 26, (the Privacy Protection Act of 1976) and the Health Insurance Portability and Accountability Act of 1996. Access to information concerning applicants or enrollees must be restricted to persons who are subject to standards of confidentiality comparable to those DMAS imposes on its own employees and agents. The Contractor attests that the data will be safeguarded according to the provisions of the written, DMAS approved Security Plan meeting the general requirements outlined in Attachment 2. The exact content of the Security Plan will be negotiated between the Contractor and DMAS Internal Audit since the general data processing environment of each Contractor will be different. In no event shall the Contractor provide, grant, allow, or otherwise give, access to the Data in contravention of the requirements of its approved Security Plan. The Contractor assumes all liabilities under both state and federal law in the event that Data is disclosed in violation of 42 CFR 431, or in violation of any other applicable state and federal laws and regulations.

The Contractor shall dispose of all DMAS Data upon termination of the contract according to provisions for such disposal contained in its Security Plan. Contractor certifies that all Data, whether electronic or printed, in any form, original, reproduced, or duplicated, has been disposed of in accordance with the provisions of the Security Plan within thirty (30) days of completion of the project or termination of the contract. No copies, reproductions or otherwise, in whole or in part, in whatever form, of the Data shall be retained by the Contractor following completion of the contract. The Contractor acknowledges that ownership of the Data remains with DMAS at all times.

A copy of all oral, written or electronic reports, presentations or other materials, in any form, whatsoever based, in whole or in part, on the Data must be reviewed and approved by DMAS prior to its release to any third party.

The Contractor will include, on the first page of all materials released to third parties, the following statement: "The following material may contain and may be based, in whole or in part, upon data provided by the Department of Medical Assistance Services, which retains all rights of ownership thereto. No copies or reproductions, electronic or otherwise, in whole or in part, of the following material may be made without the express written permission of the Department of Medical Assistance Services."

The Contractor acknowledges that DMAS reserves the right to audit for compliance with the terms of this agreement and for compliance with federal and state laws and regulations and for implementation of the terms of the approved Security Plan.

The Contractor hereby agrees to comply with all of the requirements set forth herein.

ATTACHMENT X
BASIC SECURITY PLAN

DATA SECURITY PLAN ATTACHMENT

THIS ATTACHMENT supplements and is made a part of the Contract by and between the Department of Medical Assistance Services (herein referred to as "the Department") and [name Contractor] (herein referred to as "the Contractor").

General Requirements

The purpose of these requirements is to provide a framework for maintaining confidentiality and security of data compiled for the Department, the Contractor or its subcontractors. This data is the property of the Department.

The Contractor shall submit a written contractor Data Security Plan within thirty (30) days of the execution of this Agreement by general mail to the Department at the address in this contract. The Contractor's Data Security Plan shall describe the manner in which the Contractor will use the Department's data and the procedures the Contractor will employ to secure the data. The Department's HIPAA Office of Privacy and Security will work with the Contractor in the preparation of the Contractor's Data Security Plan. The uses of the Department's data detailed in the Contractor's Data Security Plan shall not be in violation of purposes directly related to State Plan administration included in 42 CFR § 431.302[1]. No other uses of the Department's data outside of the purposes stated in the Contractor's Data Security Plan will be allowed. The Contractor agrees to restrict the release of information necessary to serve the stated purpose described in the Contractors Data Security Plan. The Contractor Associate agrees that there will be no commercial use or marketing use of the Department's data, which he or she receives or creates in fulfillment of his contractual obligations. Upon reasonable request, the Contractor shall give the Department access for inspection and copying to the Contractor's facilities used for the maintenance or processing of Protected Health Information (PHI), and to its books, records, practices, policies and procedures concerning the use and disclosure of PHI, for the purpose of determining the Contractor's compliance with this Agreement.

The Contractor agrees to fully comply with all federal and state laws and regulations, especially 42 CFR § 431, Subpart F, and Virginia Code Section 2.1-377, et. seq. Access to information concerning applicants or recipients must be restricted to individuals who are subject to standards of confidentiality comparable to those the Department imposes on its own workforce and vendors. The Contractor attests that the data will be safeguarded according to the provisions of the written, Department approved, contractor Data Security Plan meeting the general requirements outlined in Part II of this document. The exact content of the Contractor's Data Security Plan will be negotiated between the Contractor and the Department's HIPAA Office of Privacy and Security since the general data processing environment of each Contractor will be different. In no event shall the Contractor provide, grant, allow, or otherwise give access to the data in contravention of the requirements of its approved Contractor Data Security Plan. The Contractor assumes all liabilities under both state and federal law in the event that data is

disclosed in violation of 42 CFR § 431, or in violation of any other applicable state and federal laws and regulations.

The Contractor shall dispose of all Department data upon termination of the contract according to provisions for such disposal contained in its Contractor Data Security Plan. The Contractor certifies that all data, whether electronic or printed, in any form: original, reproduced, or duplicated, has been disposed of in accordance with the provisions of the Contractor Data Security Plan within thirty (30) days of completion of the project or termination of the contract. No copies, reproductions or otherwise, in whole or in part, in whatever form, of the data shall be retained by the Contractor following completion of the contract. The Contractor acknowledges that ownership of the data remains with the Department at all times.

II. Format for a Basic Business Associate Data Security Plan

1. State the nature of the requesting organization's relationship with the Department Entity. In the absence of a contract or some other formal contractual relationship with the Department, please provide an explanation of how the proposed use of the Department's data is directly related to State Plan Administration [see 42 CFR § 431.302].

2. Provide the name of the Contractor's designated Information Security Officer, including full name, address, phone number and fax number. State the individual's relation to the business function.

3. Provide the names and position designations of all individuals who will have access to the data at or for the Contractor.

4. State the exact purpose(s) for which the data will be used.

5. Describe the format (e.g., tape, paper, disk or electronic transfer) in which the Contractor envisions receiving the required data from the Department.

6. Describe the medium within the Contractor's organization upon which the data will be stored (e.g., will the data be on a disk pack accessible by the Contractor's mainframe; will the data reside on a floppy disk stored in a box of similar disks beside the Contractor's PC; will the data be accessible to many users through a network on the Internet or on an Intranet?)

7. Describe the provisions the Contractor is taking to physically safeguard The Department data in whatever form it has been provided or created. As part of the Contractor Data Security Plan for the Department, the Contractor must include a copy of any security plan, security policies, or security procedures currently in effect within the organization.

8. Identify all individuals (or entities) to whom the data will be distributed as a result of the business function.

9. Describe through what mechanisms and in what format the Contractor proposes to make final work products available to the Department.

10. Summarize, within the Contractor's Data Security Plan, the data retention and disposal requirements that exist in the Contract or Agreements with the Department. If the Contractor is subject to any other retention requirements, those requirements should be included in the Contractor's Data Security Plan.

11. Provide a statement of acknowledgement in the Contractor's Data Security Plan that all Department data, no matter how manipulated or summarized remains the property of the Department.

12. Describe the provisions the Contractor is taking to ensure continuity of service to the Department in the event of an emergency or other catastrophic event causing contractor business interruption (where applicable).

13. Note the existence of any insurance or bonds carried by the Contractor, which would protect the Contractor and the Department from contingent liability in the use of the data. Otherwise, provide a statement in the Data Security Plan if no such insurance coverage exists.

DATA SECURITY PLAN EXAMPLE

XYZ ORGANIZATION BUSINESS ASSOCIATE DATA SECURITY PLAN

1. State the nature of the requesting organization's relationship with DMAS. In the absence of a Business Associate Agreement or some other formal contractual relationship with DMAS, please provide an explanation of how the proposed use of DMAS data is directly related to State Plan Administration (see 42 CFR, Section 431.302).

XYZ is the contractor for DMAS contract # XXXX_XX for Preauthorization and Utilization Management Services.

2. Provide the name of the Business Associate's designated Information Security Officer, including full name, address, phone number and fax number. State the individual's relation to the business function.

Name
Title
Organization
Address
Phone
Fax

Ms. Doe oversees all IT operations at XYZ including connectivity to and data transfer between the DMAS Medicaid Management Information System (MMIS) and XYZ.

3. Provide the names and position designations of all individuals who will have access to the data at or for the Business Associate.

Associates' name, title, department

4. State the exact purpose(s) for which data will be used.

1) Medical Review
2) Report Generation

5. Describe the format (e.g., tape, paper, disk) in which the Business Associate envisions receiving the required data from DMAS.

Data is submitted from providers by telephone, fax, or mail for medical review purposes and is entered into the internal XYZ databases. Information for all review cases is stored on a XYZ Windows 2000 based server with Oracle 8i as the database management system. Data are backed up to magnetic tape at the end of each business day and stored offsite at X location.

6. Describe the medium within the Business Associate's organization upon which the data will be stored (e.g., will the data be on a disk pack accessible by the Business Associate's mainframe; will the data reside on a floppy disk stored in a box of similar disks beside the Business Associate's PC; will the data be accessible to many users through a network on the Internet or on an Intranet?)

To ensure confidentiality and security, XYZ maintains a filing process that includes staff assigned for file maintenance, file retrieval, file purging and file preparation for offsite storage. XYZ provides DMAS with access to all files during normal hours of operation.

XYZ maintains file storage facilities for on-site review of the previous six months of documentation. XYZ maintains offsite storage for files older than 6 months at X storage facility. Files stored at this facility are returned to our location within 24 hours of the retrieval request. Emergency same-day retrieval service is also available.

Information pertaining to all requests is entered at the Windows 2000 desktop using Visual Basic developed screens and is stored on our Windows 2000 based server with Oracle 8i as the database management system. Data is backed up to magnetic tape at the end of each business day and stored offsite at x location. Access to the server for administrative purposes is limited to the Systems Manager, John Doe, and the Database Administrator, Jane Doe. User access to the system and the case review data is controlled by Windows 2000 security provisions with additional access limitation imposed on the database side via Oracle. Both user ID's and passwords are required for access. Passwords are automatically aged by the system and must be changed by each user every thirty (30) days.

The Virginia Medicaid system is housed on a Hewlett Packard Pentium III 600 MHz server with 384k memory. Hard disk storage includes a RAID-5 disk array with four – 9.1 KB disk drives, a redundant power supply and tape backup. This system will have the same connectivity to DMAS MMIS as described above.

Data are never sent over the Internet. XYZ uses a secure 'internal' email system. Connectivity to our network is through a LAN in our Richmond office that then accesses our corporate email server via a dedicated frame delay connection line. We do not use Internet email facilities to send any DMAS information. Please refer to the response to question 7 for further information.

XYZ currently connects to the MMIS at x location via a frame-relay connection from our Richmond office to DMAS.

Future Operating Environment

As required by our new contract with DMAS we will eventually connect to MMIS at X location directly, rather than connecting at DMAS. We will use a serial connection between the XYZ provided CSU/DSU and the X router. Based on the expected volume, we will provide a 64 KBPS frame relay dedicated data line to the current DMAS Fiscal Agent's data center. In the event that traffic increases significantly, additional bandwidth can be added. At both ends of the frame relay data line, XYZ will provide an ADTRAN TSU LT T1/Fractional T1 CSU/DSU. A public address subnet will be provided if requested by Fiscal Agent for router-to-router connection. There will be a serial router port connection to the CSU/DSU on the Fiscal Agent side of the connection. As required, only public IP addresses will be presented across the data line. No connections across the Internet will be used.

XYZ will employ terminal emulation software – Eicon Access for Windows 3270 – to access the system from our desktop personal computers. Our existing employees and the DMAS contract monitors currently use this software to provide 3270 emulation for access to the DMAS computer system.

While our existing computer system easily and effectively handles all the processing required to support the DMAS requirements, every automated system can be improved. To reduce our maintenance costs, improve system access to DMAS authorized users and improve reliability, we are enhancing our existing Visual Basic/Oracle 8i Based computer system to a configuration that can also employ a browser-based client under Windows 95/98/2000. This browser-based access will use a secure Virtual Private Network (VPN) connection to XYZ's Windows 2000 server supporting the Oracle 8i-database management system. This new environment will make it possible to extend access to the system to any DMAS approved user with access to the Internet, subject to encryption in the manner prescribed in the HCFA Internet Security Policy dated 11/24/1998.

Based on provider interest and approval of DMAS, we will develop ASP based forms to allow providers using their Internet connection to enter data about the pre-authorization request directly from their location – reducing or eliminating the need to fax this information to XYZ. Entry of information by the providers at the source of data to the XYZ maintained database means that errors and processing

time associated with printing the fax, routing the fax to the appropriate reviewer and subsequent entry of the information to our computer system are eliminated.

7. Describe the provisions the Business Associate is taking to physically safeguard DMAS data in whatever form it has been provided or created. As part of the Business Associate Data Security Plan for DMAS, the Business Associate must include a copy of any security plan, security policies, or security procedures currently in effect within the organization.

Our data security and confidentiality plans are summarized and described below.

XYZ is well aware of the confidential nature of the information that we will receive and process, both in paper and electronic format. We also understand that all data provided by DMAS to XYZ remains the property of DMAS. We will use this data only for the activities needed to fully support all the requirements of this scope of work. In the event a need arises for use of the DMAS provided data for some other purpose, XYZ will obtain written permission from DMAS in advance of any use of this data. XYZ also agrees to follow federal and state confidentiality requirements as set forth in the then current Code of Federal Regulations and the then current Code of Virginia.

To ensure XYZ compliance with all of the confidentiality and security requirements associated with use and storage of health care information, all XYZ employees must adhere to the confidentiality rules and security procedures outlined in the XYZ Employee Notebook.

The notebook is updated as needed but at least every year to reflect current XYZ policies that its employees must adhere to. Every new employee is provided with a copy of the manual, and our Human Resources Department reviews the key section dealing with our confidentiality policy. This section includes information about:

- Access and disclosure of confidential information
- Responsibility for confidentiality vested in a single individual
- Research and statistical reporting
- Legal requests for information
- Disclosure, monitoring, review and evaluation
- Disclosure of privileged data and information to third parties
- Patient access to XYZ data and information
- Prospective employee background investigations
- Trustee and employee access and training
- Document accountability
- Building security
- Communications security, ADP security
- Subcontract requirements
- Responsibilities of medical review coordinators
- Requests for the generation of non-privileged information
- Penalties for disclosure of confidential information

HIPAA mandates new security standards to protect an individual's health information, while permitting the appropriate access and use of that information by health care providers, clearinghouses, and health plans. The standard mandates safeguards for physical storage and maintenance, transmission and access to individual health information regardless of the medium used. In addition to our institutionalization of confidentiality and security policies discussed above, XYZ will comply with all HIPAA data security requirements as needed.
These are some examples of steps we already have in place in:

- We have in place appropriate physical safeguards to protect data integrity, confidentiality and availability. Our offices are secure and require a key or swipe card for entry. Only XYZ employees and four DMAS contract monitors are granted these keys/cards. Visitors to XYZ facilities are required to register and wear visitor's passes. In addition a XYZ employee must escort them. Our computer servers and databases are housed in a locked room within our secure facility. Access to the computer room is limited to information technology personnel. XYZ employees escort maintenance personnel at all times. Smoke detectors and automated sprinkler systems are installed to protect from fire.

- We have developed and implemented administrative procedures to guard data integrity, confidentiality and availability. All employees are required to read and sign a non-disclosure agreement as a condition of employment. An employee handbook has been developed that details all employee responsibilities and acceptable conduct and the actions that may be taken in the event of improper conduct. Security awareness training is conducted periodically. All data is backed up on a daily basis and secured in a fireproof safe. Virus detection and correction software is installed on all PCs and corporate servers. Updates to this software are made on a bi-weekly basis.

- We have implemented technical security services to guard data integrity, confidentiality and availability. Access to our local area network and the services available on that network are limited to authorized users. The program manager for each program grants authorization and a unique user id and password are used to gain access. Passwords are automatically retired every thirty (30) days. Access to the automated applications and underlying databases requires a separate logon and password. Access is further controlled on a "need" basis, providing either no access, read only, or write access to data. Users are automatically denied access following 3 failed logon attempts. System logs record user logon attempts, and applications capture information about who has added, modified or deleted records.

- Finally we have implemented appropriate technical security mechanisms that include the processes to prevent unauthorized access to data that is transmitted over a communications network. Our Systems Administrator, who grants access to users only upon program manager approval, controls access to our network. Currently, remote access to our local area network (and thence to the applications and databases) is highly restricted, and is used only from system administration. As we migrate our applications to a "web" ready environment, we will only support dial-in access (to users approved by DMAS) via a

limited number of dial up circuits or via the Internet using Virtual Private Network (VPN) technology. VPN supports user authentication via public-private key exchange and provides a secure connection from the remote user to our systems over an encrypted "virtual tunnel" through the Internet.

To ensure that our security policies and practices remain current, we will periodically assess our security risks and vulnerabilities and the mechanisms currently in place to mitigate those risks and vulnerabilities. Measures in addition to those described above will be added as needed.

8. Identify all individuals (or entities) to whom the data will be distributed as a result of the business function.

Data that identify individual recipients, providers or facilities will never be distributed to any entity outside DMAS except with the express prior consent of DMAS. Aggregated data may be used for provider training, legislative presentations etc., but also only with the prior consent of DMAS. Data may occasionally be requested by HCFA or to other federal oversight authorities for inclusion in multi-state studies, analyses or for other purposes, but again, will not be released without the consent of DMAS.

9. Describe through what mechanisms and in what format the Business Associate proposes to make final work products available to DMAS.

XYZ will use the mechanisms and formats preferred by DMAS to make final work products available. This may include electronic transmission, tape, diskette, hard copy, or any other medium requested by DMAS.

Currently the weekly, monthly, quarterly annual and ad hoc reports are sent to DMAS electronically and/or in hard copy format. XYZ does not electronically send any reports to DMAS that contain patient identifiable information.

10. Summarize, within the Business Associate Data Security Plan, the data retention and disposal requirements that exist in the Contract or Agreements with DMAS. If the Business Associate is subject to any other retention requirements, those requirements should be included in the Business Associate Data Security Plan.

To ensure confidentiality and security, XYZ maintains a filing process that includes staff assigned for file maintenance, file retrieval, file purging and file preparation for offsite storage. XYZ provides DMAS with access to all files during normal hours of operation.

XYZ currently maintains file storage facilities onsite and available for review for the previous 6 months of documentation. XYZ maintains offsite storage for files older than 6 months at x storage facility. Files stored at this facility are returned to our location within 24 hours of the retrieval request. Emergency same-day retrieval service is also available.

XYZ shreds all hard copy data that is not stored for retrieval. Any removable magnetic media that has been used for storage is degausses before disposal.

11. Provide a statement of acknowledgement in the Business Associate Data Security Plan that all DMAS data, no matter how manipulated or summarized remains the property of DMAS.

XYZ is well aware of the confidential nature of the information that we will receive and process, both in paper and electronic format. We also understand that all data provided by DMAS to XYZ remains the property of DMAS. We will use this data only for the activities needed to fully support all the requirements of this scope of work. In the event a need arises for use of the DMAS provided data for some other purpose, XYZ will obtain written permission from DMAS in advance of any use of this data. XYZ also agrees to follow federal and state confidentiality requirements as set forth in the then current Code of Federal Regulations and the then current Code of Virginia.

12. Describe the provisions the Business Associate is taking to ensure continuity of service to DMAS in the event of an emergency or other catastrophic event causing Business Associate business interruption (where applicable).

XYZ has instituted a policy detailing our procedures for preauthorization during loss of connectivity. The following policies may be found in our XYZ -- Virginia Operations Policy and Procedures Manual and are also attached to this document.

- Utilization Review (Inpatient) Procedure for Loss of Connectivity.
- Utilization Management (Inpatient) Procedure for Loss of XYZ Database
- Prior-Authorization (Outpatient) Procedure for Loss of Connectivity
- Prior-Authorization (Outpatient) Procedure for Loss of XYZ Database
- Behavioral Health Review Procedure for Loss of Connectivity
- Behavioral Health Review Procedure for Loss of XYZ Database
- Community Based Care Review Procedure for Loss of Connectivity
- Community Based Care Review Procedure for Loss or XYZ Database

13. Note the existence of any insurance or bonds carried by the Business Associate, which would protect the Business Associate and DMAS from contingent liability in the use of the data. Otherwise, provide a statement in the Business Associate Data Security Plan if no such insurance coverage exists.

Our current Managed Care E&O Policy does cover “Medical Information Protection for claims arising out of the inadvertent release of medical information/records.” Our underwriter is:

Name
Title
Organization
Address
License #
Phone
Fax

Attachments:
Enclosed are additional documents including Policies and Procedures that XYZ has issued in order to meet the guidelines of the Data Security Plan.

ATTACHMENT XI
THIRD PARTY ACCIDENT REPORT

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
FINANCIAL OPERATIONS, THIRD PARTY LIABILITY UNIT
ENROLLEE THIRD PARTY ACCIDENT REPORT

Person Providing Information: _____

Telephone Number: _____

Enrollee Name: _____

ID/SSN Number: _____

Accident Type and Date: _____

_____

_____

_____

_____

Firm/Company: _____

Firm/Company Address: _____

_____

_____

_____

MCO Name: _____

Prepared By: _____ Date: _____

ATTACHMENT XII
EXAMPLES OF SPECIFIC COMPLAINTS, GRIEVANCES AND APPEALS REASONS

ACCESS TO HEALTH CARE SERVICES

- Geographic access limitations to providers and practitioners
- Availability of PCPs/specialists/behavioral and mental health providers
- PCP after hour access
- PCP phone availability during office hours (no answer, lengthy hold, busy)
- Access to urgent care and emergency care
- Out-of-network access
- Availability and timeliness of provider appointments and provision of services
- Availability of outpatient services within the network (To include HHA, labs, physical therapy, radiation therapy)
- Enrollee provisions to allow transfers to other PCPs
- Patient abandonment by PCP
- Pharmaceuticals (Based upon patient's condition, the use of generic drugs versus brand name drugs)
- Access to preventative care (immunization, prenatal, STDs, cancer)
- Access to MCO complaint and grievance procedures
- MCO enrollee notification regarding changes in the EOC and mandated benefits

UTILIZATION AND MEDICAL MANAGEMENT

- Denial of medically appropriate services covered within the enrollee contract
- Limitations on hospital length of stays for stays covered within the enrollee contract
- Timeliness of preauthorization reviews based on urgency
- Inappropriate setting for care, i.e., procedure done in an outpatient setting that should be performed in an inpatient setting
- Criteria for experimental care
- Unnecessary tests or lack of appropriate diagnostic tests
- Denial of specialist referrals allowed within the contract
- Failure to adequately document and make available to the members reasons for denial
- Unexplained death
- Denial of care for serious injuries or illnesses, the natural history of which, if untreated, are likely to result in death or to
- progress to a more severe form
- Organ transplant criteria questioned

PROVIDERS CARE AND TREATMENT

- Appropriateness of diagnosis and/or care
- Appropriateness of credentials to treat
- Failure to observe professional standards of care, state and or federal regulations governing health care quality
- Unsanitary physical environment
- Failure to observe sterile techniques or universal precautions
- Medical records-failure to keep accurate and legible records, to keep them confidential and to allow patient access
- Failure to coordinate care (Example: appropriate discharge planning)
- Rude and inappropriate treatment by provider
- Provider did not explain treatment
- Waited too long in office
- Discrimination

PAYMENT AND REIMBURSEMENT ISSUES

- Enrollee billed for covered services
- Enrollee charged inappropriately for copayments
- Provider did not get paid promptly
- Provider claim denied inappropriately
- Provider claim processed incorrectly

ADMINISTRATIVE SERVICES

- Did not receive member ID
- Enrollment decision Not Implemented
- Incorrect information on member card
- Did not receive member handbook and/or other notices

ATTACHMENT XIII
FAMIS NEWBORN REPORT

MCO NAME _____

MONTH/YEAR_____

Mother's Name	Mother's 12 Digit FAMIS ID Number	Newborn Name	Date of Birth

ATTACHMENT XIV
FAMIS ENROLLEE ADDRESS CHANGE REPORT

MCO NAME _____

MONTH/YEAR_____

MEMBER NAME	MEMBER 12 DIGIT ID NUMBER	OLD ADDRESS	NEW ADDRESS	DATE OF ADDRESS CHANGE

ATTACHMENT XV

Authorized Workforce Confidentiality Agreement

This Agreement between _____ [the Contractor] and _____ (please print), an employee of _____ hereby acknowledges that [the Entity's] records and documents are subject to strict confidentiality requirements imposed by state and federal law including 42 CFR § 431 Subpart F, Virginia Code Section 2.1-377, et. seq.

I (initial) _____ acknowledge that my supervisor, or whoever administers the data, has reviewed with me the appropriate provisions of both state and federal laws including the penalties for breaches of confidentiality.

I (initial) _____acknowledge that my supervisor, or whoever administers the data, has reviewed with me the confidentiality and security policies of [the entity].

I (initial) _____acknowledge that my supervisor or, whoever administers the data, has reviewed with me the confidentiality and security policies of our organization.

I (initial) _____acknowledge that unauthorized use, dissemination or distribution of Virginia Department of Medical Assistance Services (DMAS) confidential information is a crime.

I (initial)_____hereby agree that I will not use, disseminate or otherwise distribute confidential records or said documents or information either on paper or by electronic means other than in performance of the specific job roles I am authorized to perform.

I (initial) _____also agree that unauthorized use, dissemination or distribution of confidential information is grounds for immediate termination of my employment or contract with [the entity] and may subject me to penalties both civil and criminal.

Signed Date_____

ATTACHMENT XVI
MONTHLY EDI REPORT
MCO Provider File
File PS-F-025

FIELD NAME	PICTURE	FLD	START	END	LENGTH	DESCRIPTION
P025-PROV-MCO-RECORD			1	235	235	
P025-MCO-TRANS-CODE	X	1	1	1	1	A code that designates the type of action this record represents A = Add provider C = Change provider D = Delete provider
P025-MCO-ID	(10)	2	2	11	10	A unique identification number assigned to the MCO
P025-PROV-ID*	(10)	3	12	21	10	A unique identification number assigned to a provider
P025-PROV-TYPE	999	4	22	24	3	A code that designates the classification of a provider under the State plan (e.g., Dentist, Pharmacy)
P025-PROV-SPEC	999	5	25	27	3	The provider's certified medical specialty(ies)
P025-PROGRAM-CODE	99	6	28	29	2	The program(s) in which a provider participates 01 Medicaid 02 MEDALLION 03 Medallion II 04 Options (MCO) 05 CMM 06 TDO 07 SLH 08 FAMIS 09 Assisted Living
P025-PROV-LAST-NAME	X(30)	78	30	59	30	The last name of the provider
P024-PROV-FIRST-NAME	X(30)	8	60	89	30	The first name of the provider
P025-ADDRESS	X(60)	9	90	149	60	The address of the provider
P02----------5-CITY	X(30)	10	150	179	30	The city for the provider
P025-ZIPCODE	9(9)	11	180	188	9	The zip code of the provider
P025-PHONE-NUM	9(10)	12	189	198	10	The provider's phone number
P025-PHONE-NUM-EXT	9(4)	13	199	202	4	The provider's extension
FILLER	X(33)	14	203	235	33	

*NPI when applicable

ATTACHMENT XVII
CERTIFICATION OF ENCOUNTER DATA RELATING TO PAYMENT UNDER THE MEDICAID PROGRAM

CERTIFICATION

Pursuant to the contract(s) between Virginia and the (enter name of business entity) managed care organization (MCO), the MCO certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the Virginia Medical Assistance Program as a MCO, (insert Plan identification number(s) here). The (enter name of business) MCO acknowledges that if payment is based on encounter data, Federal regulations at 42 CFR 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The MCO hereby requests payment from the Virginia Medical Assistance Program under contracts based on encounter data submitted and in so doing makes the following certification to Virginia as required by the Federal regulations at 42 CFR 438.600 (et.al.).

The (enter name of business) MCO has reported to Virginia for the month of (indicate month and year) all new encounters (indicate type of data such as – Mental Health – Institutional, Mental Health – Professional, Medical – Institutional, Medical – Professional, Pharmacy, Transportation, Dental, Vision, Laboratory). The (enter name of business) MCO has reviewed the encounter data for the month of (indicate month and year) and I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to Virginia in this report is accurate, complete, and truthful.

NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM. I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO THE (Enter Name of Business) MCO. I UNDERSTAND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT.

Furthermore, by signing below, the Managed Care Organization attests that the paid claim amount is a proprietary field to be held as such by the Department of Medical Assistance Services. The Managed Care Organization states the following as to why protection is necessary: _____ _____. This information shall not be released, pursuant to the authority of the COV sec. 2.2-4342(F), except as required for purposes of the administration of the Title XIX State Plan for Medical Assistance.

_____

(INDICATE NAME AND TITLE (CFO, CEO, ORDELEGATE)
on behalf of

_____

(INDICATE NAME OF BUSINESS ENTITY)

_____

DATE

ATTACHMENT XVIII

CERTIFICATION OF DATA

CERTIFICATION

Pursuant to the contract(s) between Virginia and the (enter name of business entity) managed care organization (MCO), the MCO certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the Virginia Medical Assistance Program as a MCO Plan, (insert Plan identification number(s) here). The (enter name of business) MCO acknowledges that if payment is based on any information required by the State and contained in contracts, proposals, and related documents, Federal regulations at 42 CFR 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The MCO hereby requests payment from the Virginia Medical Assistance Program under contracts based on any information required by the State and contained in contracts, proposals, and related documents submitted and in so doing makes the following certification to Virginia as required by the Federal regulations at 42 CFR 438.600 (et.al.).

The (enter name of business) MCO has reported to Virginia for the period of (indicate dates) all information required by the State and contained in contracts, proposals, and related documents submitted. The (enter name of business) MCO has reviewed the information submitted for the period of (indicate dates) and I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to Virginia is accurate, complete, and truthful.

NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM. I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO THE (Enter Name of Business) MCO. I UNDERSTAND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT.

Furthermore, by signing below, the Managed Care Organization attests that the paid claim amount is a proprietary field to be held as such by the Department of Medical Assistance Services. The Managed Care Organization states the following as to why protection is necessary:

_____
_____. This information shall not be released, pursuant to the authority of the COV sec. 2.2-4342(F), except as required for purposes of the administration of the Title XIX State Plan for Medical Assistance.

_____
(INDICATE NAME AND TITLE (CFO, CEO, OR DELEGATE)
on behalf of

_____
(INDICATE NAME OF BUSINESS ENTITY)

_____
DATE

ATTACHMENT XIX

DMAS Managed Care Expansion Requirements

The following are DMAS requirements outside the managed care contracts that must be satisfied by the managed care organization (MCO) prior to any expansion being approved.

- A letter of intent at least 6 months in advance of the requested expansion date, from the MCO to DMAS requesting to expand. The letter must include the localities where the expansion is proposed, a proposed effective date, copies of BOI and VDH approval (if already obtained), a network development plan and a marketing plan. The Department shall direct its focus on MCO network development to assure access is better than what is currently available in the area the MCO seeks to expand into.

Upon approval by DMAS of the expansion request, the MCO must provide the following within 30 days of the Department's approval of request to introduce one or more manage care plans into a new area:

- A plan of action to secure advocate and community support in the planned expansion area.

- A project plan for the expansion including completion of network development, information technology requirements, and communication deadlines.

- A list of the expansion team at the MCO with their title and role on the team.

- A designee who will manage the expansion project and will work with DMAS as the primary contact.

- An assessment of political ramifications, if any, for the expansion area. DMAS will review and respond to this.

- Profit and enrollment projections for the two year period following the planned expansion.

- An outreach and education plan (both long and short term) including the names of the team when available.

- A plan detailing how the expansion will be incorporated in to the MCOs current processes.

- A list of subcontractors impacted and a communication plan for notifying the subcontractor of changes.

- A detailed care transition plan.

- Assurances that all ancillary programs (i.e. prenatal, disease state management) will be operational and in place prior to implementation.

- A detailed request from DMAS for information which will assist the MCO in its expansion process. This could include information like the MEDALLION PCPs in the expansion area and their panel size or a request for assistance in contacting major providers or hospital systems during the contracting process.

- A draft of the member, marketing and provider materials at least 120 days before the planned expansion date. DMAS will review and respond within 30 days of receipt of the materials.

- A primary care network that includes contracting with all area health departments, major hospitals, community services boards (CSBs), the top 50% utilized primary care providers, OB/GYNs and pediatricians in both rural and urban areas.

- A specialty care network plan detailing development for early intervention providers, laboratory, vision, pharmacy, psychiatric, and transportation services.

- A network development plan must include the following specialties:

Allergy and Immunology	Pediatric Critical Care
Audiologist	Pediatric Development
Audiology	Pediatric Endocrinology
Endocrinology	Pediatric Gastroenterology
Family Medicine	Pediatric General Surgery
Gastroenterology	Pediatric Genetics
Geriatric	Pediatric Hemotology/Oncology
Gynocologic Oncology	Pediatric Nephrology
Health Department	Pediatric Orthopedics
Home Health	Pediatric Pulmonology
Hospice	Pediatric Specialist
Hospitalist	Physical Medicine
Infectious Disease	Physical Therapy
LCSW	Prosthetics and Orthotics
Maternal and Fetal Medicine	PT, OT, ST
Midwifery	Pulmonary Medicine
Nephrology	Radiation Oncology
Nurse Practitioner	Rehabilitation
Occupational Medicine	Surgery (various)
Oncology, Hematology	Transplant Surgery
Orthopedics	Urgent Care
Otolaryngology	
Pathology	
Pediatric Allergy & Immunology	

The Department will determine network adequacy based on specific utilization for the expansion area not later than 90 days prior to the planned implementation date. The MCO must meet any network requirements established by the Department. The MCO must demonstrate adaptability to the special requirements of certain populations like pregnancy women in rural areas. The final MCO network must be submitted before pre-assignment deadlines established by the Department.

- A written plan indicating the date when BOI and VDH approval will be secured, if at the time of the initial letter of intent BOI and VDH approval are not secured. The MCO must provide the Department with copies of BOI and VDH letters.

- In order to pursue the expansion, if approved by the Department, the MCO will submit a letter accepting the terms of the contract and of these guidelines. The MCO must provide written assurances that it will accept both FAMIS and Medallion II enrollees, will submit to an operational readiness review, and will adhere to the all requirements of the contract (including reporting).

ATTACHMENT XX
MCO SPECIFIC CONTRACT TERMS

1. FAMIS COUNTIES/CITIES IN WHICH ENROLLMENT IS ACCEPTED:

2. Maximum Enrollment level: To be determined by DMAS.

3. This contract shall become effective on July 1, 2006 and continue to June 30, 2007.

4. Capitation rate as a percent of maximum: 100%.

ATTACHMENT XX – MCO SIGNATURE PAGE
(Continued)

IN WITNESS HEREOF, the parties have caused this contract to be duly executed intending to be bound thereby.

CONTRACTOR	**DEPARTMENT OF MEDICAL ASSISTANCE SERVICES**
By: _____	By: _____
Title: _____	Title: _____
Date: _____	Date: _____